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ACUTE EXFOLIATIVE DERMATITIS.*

See insert plate

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I present a case history of this rare disease, which is synonymous with pityriasis rubra and exfoliative dermatitis neonatorum. The cause is unknown, though supposable causes are infection and tuberculosis.

As its name indicates, we have a characteristic symptom—shedding of the epidermis. The skin peels, or curls up in various sized, thin, papery flakes. It involves the entire body in most cases. In the beginning of the disease, the peeling and shedding does not occur, but after some days it appears. The disease is very intractable. Even if recovery ensues, the disease will most likely play a return engagement at a later date. The case I wish to cite, of baby R——, is as follows:

Grandmother died of tuberculosis of lungs; grandfather healthy; parents both healthy; no history of any antecedent skin disease; no specific history. The child was born in a normal labor. The umbilicus was slow in healing and was somewhat irritated. It was when the infant was about three weeks old that the parents first noticed that the skin around the umbilicus and under the band, was reddened. But not until it was nearly two months old, or after the disease had progressed some four or five weeks, was it thought necessary to consult a physician.

On examination, I found almost the whole body red and the skin peeling. At the flexures, it was parchment-like, with red furrows, almost bleeding. The babe looked as if it had been scalded. The flakes were cast off almost daily, in size from ¼ inch to ⅜ inch in width, and ½ inch to 1 or 1½ inches in length. At times, quite a large area of

*Read by title before the Kansas Medical Society at Topeka, May 7, 8. 9, 1906.

healthy-looking surface would appear; but in a day or two the exfoliation was as bad as before. There was some fever, ranging from 100 degrees to 102 degrees; and a most stubborn diarrhoea developed, the stools ranged from 10 to 20 per day. Later in the disease. the body seemed to be slightly swollen. The kidneys acted fairly well.

As to the diagnosis in this case, it did not present the symptoms of throat trouble, high temperature and general complications of scarlet fever; nor the great itching, papules, vesicles, crusts, or moisture of eczema. It was too red for ichthyosis. It did not have the mortar-like splotches on an indurated base as in psoriasis. Neither did it show papular lesions nor thickened skin, as in Lichen Ruber, and was also more general; nor did it show blebs and bullae as in pemphigus foliaceous.

The treatment, (which was unsatisfactory) was in general aiding digestion, rendering the bowels more aseptic, and general tonics, as iron, arsenic, and strychnia. Pilo carpine and thyroid extract have been recommended, but were not tried in this case. Locally, olive oil, Lassar's paste and the new † diachylon ointment were used. The object of this was the protection of the skin. The patient died at the age of four months. or after about three months' illness.

SKIN GRAFTING*.

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"Tread not upon the flowers while gazing at the stars." This is a time-worn phrase, whose beauty has excited admiration and elicited eloquence in nearly every hamlet in our land. It is not my subject tonight, but the thought it conveys: That while in search of the greater things, the truths that mark epochs in the history of medicine, that are stars in the firmament of the medical science, let us not tread under our feet the little things, the details, the minor procedures, that not only add to the comfort of our patients, but shorten convalescence and effect a more perfect recovery. When asked to contribute something for this discussion, it occurred to me, after looking the ground over, that skin grafting is one of the little flowers that have been overlooked in the general stampede for greater things. So I pluck it and present it to you with a few observations I have been able to make from cases coming under my care.

As you all know, the first successful method of skin grafting was that advocated and practiced with some success by Reverdin. It consisted of pushing small bits of skin into little holes punched into the granula-

†Bismuthi oxidi dr 1 Acidi oleici, oz 1. Cerae albae, dr. 111. Vaselinae dr. x. olei rosarum q. s

*Read before the Reno County Medical Society.

tions with the sharp end of a probe. This was followed by the Thiersch method, in which the graft, a strip about the width of a finger and as long as practicable was lifted with a razor. The graft consisted, as nearly as possible, of epithelium only, and those grafts which included much of the fibrous layer were found to possess considerably lower vitality. Profiting by this lesson, Lusk attempted skin grafting by utilizing the epithelial layer secured by a blister. He is credited with considerable success, which from experience I hesitate to grant, for in three cases coming under my observation. while in hospital work, in which every possible detail of the procedure was carefully attended to, there was absolute failure in every instance. It seems hardly likely that an irritant so violent as to cause an exudate of serum beneath the horny layer of the skin would leave much vitality in that layer.

My greatest success in skin grafting has been in the use of the Thiersch method with certain minor modifications, which I will give you in the order in which they are reached when handling a case.

First, the surface on which you expect to plant the grafts must be clean and when I say this, I do not mean a sloughing surface that has been irrigated till apparently clean. I mean a surface from which the dressing can be removed at the end of twenty-four hours, and show practically no pus. In my experience, this result is best obtained by the use of several layers of plain gauze wrung out of a carbolized solution and applied to the surface and covered with gutta percha tissue or oiled silk. The next day irrigate with soap and hot water, rinse with plain water and apply dressing of bovinine covered with tissue. This I have found useful both as an antiseptic and as a local tissue food. Alternate the carbolized and bovinine dressing and every third day, to prevent hypertrophy of the granulations, apply a dry dressing of boric acid straight. If the denudation is the result of trauma, it is best to have the surface clean and ready for grafting in a week or less, as after that the granulations are sufficiently hypertrophied and soggy to lower the vitality, and consequently reduce the probability of the graft adhering. If the surface is of long standing, such as we have in old varicose ulcers, it is necessary to remove the fibrous coating which here develops with either the curette or scalpel, preferably the latter as it leaves a smoother, cleaner surface. Then instead of applying the grafts immediately as many do, I prefer to wait a couple of days. This gives the time for the damaged tissue to be absorbed, for granulations to spring up ready to attack the grafts and for hemorrhage to cease, so there will be no clots interposed between the grafts and the surface. If the case is one that has stood a week or ten days, I usually apply a glycerine dressing the

day before grafting. This relieves any oedema of the granulations and establishes a healthy circulation in the capillaries.

In the operation of the skin grafting, the surface from which the grafts are to be removed, preferably the antero-external surface of the thigh or the deltoid surface of the arm, should be washed with soft cloth and mild soap and water, then rinsed with saline solutions and shaved. No antiseptics, whatever, should be used. The grafts should be removed by an assistant with a sterile razor, and immediately immersed in a warm saline solution, without the graft being displaced from the razor. He then takes another razor, and removes another graft. The operator takes the razor carrying the graft and applying the end of the graft to the denuded surface, holds it in position with a probe while he slowly slips the razor backward, spreading the graft as it goes. These grafts should be kept moist with warm saline solution, and applied so as to leave about ⅛ of an inch space between them for drainage, and if the grafts are very wide, it is well to follow the plan advocated by Dr. Harrelson of Kansas City, that of punching small holes through the grafts with a harness punch. This allows a free drainage, which is absolutely essential.

If the grafts are placed too far apart, care must be exercised or granulations will develop between them, and overlapping the edge of the epithelial island, prevent its spreading and finally cause it to be absorbed.

As a dressing, there is nothing better than sterilized gutta percha tissue in strips an inch wide, placed like the weather boards on a house care being taken to place the strips at right angles to the long axis of the grafts. By this arrangement when it is necessary to dress the surface, we can begin at the eaves of the house, so to speak, and, by rolling the upper strip from below upward, remove all the strips without disturbing the underlying grafts.

Next to the strips, I apply several layers of plain gauze, moistened in saline solution, and covered with gutta percha tissue. Over this, cotton and a roller bandage as snug as compatible with good circulation. The moist dressing guarantees free drainage and the snug bandage insures close approximation between the grafts and granulating surface, two points absolutely essential to success.

Contrary to the teachings of the best authorities, I have obtained the best result by changing the first dressing at the end of twenty-four hours.

Great care should be exercised in making the first three or four

dressings lest the grafts be displaced. Use warm saline solutions, only, for irrigation, and let it have no force when striking the grafts.

After about four days, I dispense with the strips all together, and if at this time there are any points of granulation that the epithelium seems backward when invading,I touch them with silver nitrate and apply dry dressings.

In most cases of skin grafting, grafts are taken from the patient himself, and as patients that require skin grafting are nearly always cases of lowered vitality, it stands to reason that better results are obtained where the grafts can be secured from healthy, clear-skinned-subjects just reach ng maturity.

In my experience, the best results were obtained when the grafts were taken from subjects of the opposite sex. Whether this was a coincident or whether there is a greater affinity existing between elements of the opposite sex than between elements of the same sex, I am unable to say. Whether nature has extended in a lesser degree the affinity existing between the spermatozoon and ovum, which are products of the epithelium, to the epithelium itself, remains to be demonstrated. The success of the above procedure, however, by means of which I applied sixty-one grafts, at one sitting and had the good fortune to have them all adhere, seems to furnish some grounds for such a supposition.

Coeducation was roundly condemned by President G. Stanley Hall, of Clark University, in his paper recently read before the American Academy of Medicine, in Boston. From his profound studies of adolescence, Dr. Hall is entitled to consideration and his opinions will have great weight in the present tendency to separate the sexes in the public schools after 12 years of age. It is quite likely that the vast majority of the medical profession already agree with Dr. Hall though from different motives. His opinion is based upon the fact that the life role of men requires a set of mental characteristics, the opposite of those of women, and that to modify either sex by training it in the atmosphere of the other, is to unfit it for its struggles for existence. A compromise of methods is unsuitable for either. Boys must be trained to greater manliness and girls to greater womanliness, so that each will be able to supplement the other. Coeducation may not produce long-haired men and short-haired women, but its tendency is in that direction.—Am. Med.

SUPERSTITION IN MEDICINE.

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From time immemorial, man has been superstitious, and has ever been prone to exhibit this weakness in the field of medicine.

The ancient Egyptians were zealous students of medicine, but believed in charms. In addition to drugs they had recourse to dreams, wizards and gifts to their sacred animals. Also certain charms were written on papyrus, which they carried about with them to cure as well as prevent disease.

Their physicians in treating disease were obliged to follow out certain rules laid down in books, and any deviation from this standard meant death to the physician if his patient died. However, in some instances, these restrictions were removed after the third day, when the physician could use his own judgment.

The mixtures these ancients used were nauseous to a high degree. Often patients were obliged to eat raw meat. Such concoctions as blood, beer and milk, were boiled up together and swallowed while hot. Fish gall and the fat, bones and skins of such creatures as bats, crocodiles, vultures and lizards were standard pharmaceutical preparations!

In addition to giving these remedies, it was necessary that the physician discover what particular evil spirit possessed his patient and drive it out or destroy it. To accomplish this feat he must use very great magic.

The Babylonians had no doctors. When a person became ill, he was taken to the public square where it was the duty of the passerby to enquire of him the nature of his malady and give him any advice that might assist in a cure.

The Jews seem to have been less superstitious concerning medicine than any contemporaneous people. There is no mention whatever in the Bible, of the use of charms to cure diseases.

The Greeks and Romans, although accomplishing something of real value in medicine were firm believers in magic.

The Finns were given to the recitation of long incantations to cure disease.

Perhaps the belief in the occult was as great during the Middle Ages as at any time previous. The progress of medicine during this time was greatly impeded because the priesthood would not allow human

bodies to be dissected. They thought it impious to commit such an act on something made in the image of God. However, they were less considerate of live human beings and literally dissected many on the rack and other instruments of torture.

During the reign of Phillip II of Spain, a doctor was sentenced to death because he performed a surgical operation. The king eventually gave him his freedom on agreement that the physician would make a journey to the Holy Land and thus atone for his crime! This the poor doctor did and died there in poverty and exile.

During the 16th century a medical work was translated from the German, entitled, "A most excellent and perfecte homish apothecarye or physike booke for all the grefes and diseases of the bodye." Here is a prescription found in the book: "If the head doth ake so sore by reason of a runnege that he cannot snoffe hys nose, bath hys fete in a depe tub until the knees and give him this medicine.... which riseth into his head and dryeth his moyst braynes."

The following treatment is advocated for dizziness: "He may take the braynes of a hogge, and rost the same upon a grede yron and cut slices thereof and lay to the greved parts."

During the 15th and 16th centuries it was thought the carrying of a lion's eye in one's pocket made him bold and a terror to his enemies. Weak eyes were treated by hanging the tongue of a fox about the patient's neck. It was believed a man could be made very talkative by eating the tongues of ducks and such creatures as were given to much babbling. No mention is made of a prescription for making women more talkative, so we must draw our own conclusions!

To stop hemorrhage of the nose, a toad either alive or dead, was applied to the back of the neck. One form of malaria was treated by placing the fourth book of Homer's Iliad under the patient's pillow. Baked toads were put in silken bags and hung around the neck to prevent disease.

This superstition and mysticism was prevalent among physicians as well as laymen. Doctors, however, once and forever, broke away from the occult when in 1628, Wm. Harvey gave to the world his immortal work on the circulation of the blood. Truth had at last come to reign in a department so long in chaos. From Harvey's discovery has come modern scientific physiology. Now we deal with facts elicited from the laboratory. While physicians are no longer superstitious concerning the healing art and science, the same cannot he said of laymen, and otherwise intelligent laymen at that. We laugh, and say, "What a fool, this ancient to wear a dead toad about his neck." We are more refined and wear asafetida! As a matter of fact, the toad would smell

no worse and would be just as efficacious as a prophylactic, as would the asafetida. It was a U. S. senator who said of one of the greatest delusionists of this generation, that "he was being unjustly persecuted by the medical profession."

We wonder how those Egyptians could swallow such nauseous mixtures. But many of the nostrums taken into the stomachs of people at the present time are much more harmful than a mixture of blood and beer. Recently the president of one of our western universities said of a nostrum which has been proved highly injurious to the human system, "It is certainly a great and wonderful remedy."

A man is generally a fool about every business or profession except his own—but it does seem he is a bigger fool about medicine than anything else.

Superstition always has been and is still an impediment to the proper practice of medicine. That physicians are in some measure to blame for this I do not deny. They are sometimes dishonest with the public, but this dishonesty is not altogether wilful on the part of doctors. Let me illustrate by example: A skilful physician is called to a case. He makes a careful examination and informs the friends of the patient that an immediate diagnosis is impossible, that he will treat the case according to symptoms until it is possible to make an accurate diagnosis. This is the best any doctor can do at times and what they would all like to do, but, Presto! Dr. No. 2 is called in and about the first thing he hears while he is making an examination, is the action and fate of Dr. No. 1. Dr. No. 2 has his human weaknesses and proceeds to profit by his brother's mistake, or rather, misfortune. So he looks wise and gives the disease a Latin name as long as a clothes-line, whereupon the family is satisfied and Dr. No. 2 is thought to be very wise. When people learn to allow the doctors to be honest with them they will get different and better advice. Some one has said good advice consists in finding out what man wants you to tell him and advising him accordingly. This is too frequently the case in the practice of medicine. The ever-credulous laymen are spending thousands of dollars each year that are worse than thrown away, for in most instances distinct harm accrues from using the product purchased. There is no greater field for the exercise of common sense than that of medicine. Apropos of the last statement, there are good reasons for optimistic views along this line. The average man will in time learn that the special diseased conditions are the exception and that he can avoid such conditions by the proper observation of physiological laws. Medicine of the future bids fair to be more in the order of prophylaxis than therapeutics. A physician who cures his fellow-men of disease is a great blessing to them,

but he who can prevent mankind from contracting disease is still greater. We become ill because we abuse our bodies and minds. He is wise who exercises self-restraint, bathes regularly and often, uses wholesome food and chews it well, who reads good literature, thinks pure thoughts and cultivates a cheerful disposition toward his fellow man.

THE MAXWELL METHOD OF TREATING INTRA-CAPSULAR FRACTURES OF THE FEMUR.

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The late Dr. T. J. Maxwell of Keokuk, Iowa, deserves full credit as the originator of the plan of treatment which I am about to present. In the bulletin of the Keokuk Medical College, under date of December, 1904, the doctor in the opening paragraph says: "Fracture of the neck of the femur has been the burden of my labor in surgery for thirty-four years; but like poor Cassandra at the Court of Priam, my message has met with unbelief or indifference until recently good strong men have accepted it and verified the truth and successful results by practice. I contribute this as a boon to thousands of old persons past fifty, who may and will be rescued from invalidism. These persons, mostly old ladies, appeal to us for better treatment than surgery has offered to us in the past. We speak confidently for what we offer, as we have nearly one hundred successful cases to substantiate our contention." Intra-capsular fractures of the femur, as the name implies, are fractures occurring across the neck of the femur and lying wholly within the capsule, whether or not the fracture is wholly within or partly within and partly extra-capsular is of little moment and a question quite impossible to surely diagnose. These fractures occur most frequently in elderly people and the female is more liable in the ratio of about two to one. This fracture is produced as a rule from very slight causes, a fall upon the hip, a trip in a fold of carpet, and cases have been recorded as happening from turning in bed. Sir Astley Cooper claimed the most frequent cause in London was stepping or slipping off the edge of the sidewalk on to the horse pavement, thereby bringing the

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weight of the body in a perpendicular direction upon the neck of the bone. Few cases occur before the age of fifty years; the neck of the bone as age advances, undergoes remarkable changes; the shape changes the size alters and structure is modified. In shape the head and neck become more horizontal forming more nearly a right angle with the shaft; especially is this true in women. The neck becomes somewhat atrophied and in structure more fragile by the absorption of the animal matter of the bone, the spongy tissue cells becoming more rarified and filled with fat.

The symptoms of intra-capsular fracture will depend upon whether or not the fracture is complete or as in some cases impacted. In the latter if by a direct blow upon the hip the parts are forcibly driven into each other, there may be very little deformity with practically no shortening and in any case where a fracture is feared the patient should be completely anesthetized before any amount of manipulation is done. Where the fracture is complete there is shortening, increased mobility, utter helplessness of the affected limb, with marked eversion of the foot; the hip is less prominent than its fellow, the great trochanter will be found to lie posterior to the one of the opposite side and hugging closely the acetabulum. In impacted fractures there may be inversion or eversion owing to the part of the neck impacted. Whichever condition obtains, the leg cannot be rotated to produce an eversion in case of inversion or vice-versa without breaking up the impaction and for this reason the limb should alway be handled gently and where possible under an anesthetic. The causes producing the deformity are well-known only the lower fragment is acted upon by the displacing forces. Those strong muscles which are attached ahout the trochanters and upper shaft pull the lower fragment upward causing shortening, rotating the limb externally causing eversion and strong adduction which flattens the hip.

What is the teaching of modern surgical writers with reference to the prognosis and results of intra-capsular fracture? I quote from Scudder on Fractures, page 268:

"In the very feeble and aged, the shock of a fracture of the neck of the femur is severe. The danger to life in these cases is great. An elderly patient may die of shock within two or three days or within a week of hypostatic pneumonia or he may live several weeks and die of exhaustion because of pain and the enforced confinement. If the fracture can be treated with proper immobilization, union will occur in most cases. The impacted cases will unite; the unimpacted cases may unite." "Of especial value in this connection are the conditions existing in sixteen cases of fracture of the hip, many years after the accident. These sixteen cases were treated at the Massachusetts General Hospital by gentle traction and immobilization, for periods varying from a few weeks to a few months. The patients then went about with crutches. No other treatment was used. Nearly all the cases were unimpacted either primarily or secondarily. At the time of the accident seven cases were between forty-two and forty-seven

years old, the remainder—with two exceptions, whose ages are not stated—were over fifty; three were over sixty years old. These cases reported for examination from two and one-half to twenty-four and one-half years after the accident. Thirteen of the cases have impairment of the functional usefulness of the leg; a weakness of the limb necessitates a crutch in many instances; all movements at the hip somewhat restricted; atrophy of the muscles of the thigh, buttock and calf of the leg; a decided limp, requiring a cane; pain in the hip extending down the thigh even to the sole of the foot; pain in the hip at night; pain in going upstairs and stooping over. In only two cases out of the sixteen could it be said that the leg was functionally useful."

If this is the most favorable prognosis and result which modern surgery can offer, the case is indeed a gloomy one, and one which in the light of the brilliant achievements in other fields of surgery ought not to be satisfactory so long as there is any possibility for better results. I do not share in the opinion that such results are necessary; I believe that too much stress has been laid by surgical writers upon degeneracy of bone and lack of vital energy and not enough upon failure in bringing and holding the fragments in coaptation.

As stated before, the displacing forces are upward, external rotation and adduction. Then certainly the treatment following out the cardinal principles upon which every fracture is reduced and held, if properly treated, is that of overcoming the displacing forces, thus bringing the parts into apposition and by proper appliances hold them is such position. We maintain that the treatment of intra-capsular fractures as advocated by the latest writers, by means of extension and counter-extension in a longitudinal direction only, does not fulfill the demands of the case, to-wit; that of overcoming the displacing forces.

In detailing the treatment, I will use when I deem it necessary, the author's own words without giving further credit than this acknowledgment. For a bed, one should select a good firm mattress; the foot of the bed on the fractured side is elevated twelve inches and on the sound side eight inches. The head of the bed on the fractured side elevate four inches, the fourth leg resting on the floor. This arrangement provides for the counter-extension, the body acting as the weight. This preparation finished, the patient should be carefully laid upon the back with as little disturbance as possible to the fractured joint. The extension of the limb is accomplished by three strips of adhesive plaster, about two inches wide, placed on either side of the thigh on the outer and inner aspects, reaching from the knee well up to the body line, each set of three radiating from a common point at the knee, diverging somewhat as they pass up the thigh; by passing circular strips about the thigh at about the upper, middle and lower thirds, these longitudinal strips will be fastened and will hold all the extension necessary to bring the fragments in proper position. To the lower end of these strips sew a double thickness of heavy muslin, each band of muslin being long enough to reach from the

knee to two or three inches beyond the heel; at the lower end of the muslin strips fasten a block of wood, wide enough to prevent pressure of the muslin on the ankles. A hole bored through the block will give passage to a cord for attaching extension weight, running it over a pulley at the foot of the bed. Apply a roller bandage over the foot and leg, upon reaching the knee passing the roller over the extension strip of adhesive plaster, attached to the thigh. Bend a piece of binder's-board splint around the inner aspect of the thigh, well up in the groin and fasten it with the roller about the thigh. This binder's board is to prevent cutting into the thigh of the next appliance—the lateral extension —that which Dr. Maxwell calls the "sine qua non" of this special treatment. This is accomplished by surgeons adhesive plaster. A strip three inches wide and long enough to go around the thigh close to the body applied over the binder's board and bandage. To the ends of this adhesive plaster on the outer aspect of the thigh is attached a strong muslin bandage which in turn is fixed to a strong cord, the latter carried over a pulley at the side of the bed. This pulley is placed opposite the crest of the ilium, eighteen to twenty inches above the mattress, so that when the weight is applied, the pull will be as the body lies, upward and outward. Having completed this preparation, we are now ready to attach weights which shall hold the injured limb in proper extension. First using longitudinal extension by making steady traction until the injured leg is just as long as its fellow; then to the cord over the pulley at the foot of the bed, attach sufficient weight to hold the leg to this extension, the requisite weight varying from fifteen to twenty-five pounds according to muscularity. To the lateral extension make traction sufficient to bring the hip to equal prominence of its fellow and hold by weight, which will require from ten to twenty pounds. Internal rotation may be accomplished by traction on the strip of adhesive plaster passing under the thigh. The relief from pain will often be found to be almost immediate after the lateral extension is applied. The extension should be inspected daily. Part of the weight may be removed at the end of the first week after the irritability of the muscles has been overcome. The danger of bed-sores is obviated by raising the patient into a sitting posture every third day and rubbing the skin with alcohol. This may be done with no danger of disturbing the fracture. The time necessary to keep the patient in bed will vary from six to ten weeks.

The first case Dr. Maxwell reported occurred in 1871, woman, age 52 years.—Results—no shortening, apparently bony union, at least a useful leg, which allowed the woman to perform the household duties of a farmer's wife for twenty years.

The second case happened in 1881, male, age 72 years. Result—no

shortening or limp, a useful limb which stood the man in good stead for over twenty years. As to the point of fracture and the fact of bony union in the second case there is no longer a matter of doubt since Dr. Maxwell secured this bone after the death of the man; this bone shows a line of fracture wholly within the capsule, with perfect bony union and said bone was exhibited at the American Medical Association in 1901 at the St. Paul meeting.

The following summary is taken from the report published by the A. M. Assn. 1902, from a paper read by Dr. C. E. Ruth of Keokuk, Iowa, a colleague of Dr. Maxwell's:

"Number of cases reported, forty. No demonstratable shortening sixteen; one half-inch or less shortening, eleven; over one-half and less than one inch, ten; flail limb, no union and treatment abandoned in a few days, three; total forty. Age—over 80 years, nine; union with ability to walk well, five; no union, two; paralysis with debility from great age preventing walking, two; from 70 to 80 years, eight; non-union, none; good serviceable union, six; died of brain softening, one; union less than two months' old, quarter-inch shortening, one—total eight. From 60 to 70 years, eight; non-union, none; good, serviceable limbs, eight; no failures to secure union under 80 years of age. No failures to secure serviceable limbs in any case under seventy years of age."

Doctor A. J. Ochsner, of Chicago, than whom there are few, if any, better surgeons in this country, in the Annals of Surgery for October, 1904, reports sixteen cases of intra-capsular fractures, treated according to Dr. Maxwell's method with the following results: Age of these patients ranged thirty up to eighty years of age; all but five exceeded fifty-three years. Results: Two died, one of diabetic coma, and one of exhaustion; good union took place in the other fourteen cases and in none was there as much as three centimenters of shortening. Surely this array of testimony, including as it does fifty-six cases, ought to be sufficient to convince the most skeptical.

Against the successful issue of these cases, I would place by way of contrast the sixteen cases as reported in "Scudder's on the Treatment of Fractures," with but two out of the sixteen who secured useful limbs. These cases treated as they were by the most approved methods as taught by present day writers lead me to ask if it is reasonable to cling to the old method when the new is so much better? One case of my own I wish briefly to report:

Mrs. D. age 77 years, living on farm with son and maiden daughter, while walking across the lot fell into a furrow made by a plough (the ground being frozen) found she could not arise. She was carried into the house and a physician sent for. Diagnosis not certain. I was sent for and reached the house about seven hours after the accident. I found patient suffering from considerable shock and great pain lying upon her bed.

Examination under chloroform showed foot everted, shortening about two inches, mobility increased. Diagnosis, intra-capsular fracture.

Applied method as stated above, kept her in bed nine weeks After a day or so, the patient complained very little of pain. She got up after nine weeks in very good condition. She had been frequently raised to the sitting posture to have her back rubbed with alcohol. Results no appreciable shortening. She used limb with perfect freedom for six years, when she died at the age at the age of 83 years. She sent word to me frequently by her son, that she wished she had broken the other leg too, for the broken one was a much more useful limb than the unbroken one on account of a chronic rheumatism which at times crippled the other limb.

That hip bone is now in the museum of the Keokuk Medical College and shows a plain line of fracture wholly within the capsule with perfect bony union.

I believe that the above cases, fifty-seven in number, which I have cited will bear me out in my declaration that for efficiency in the treatment of intra-capsular fractures the Maxwell method stands out alone as the most rational and most successful yet offered to the profession

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THE X-RAY AND ITS USES.*

MARTHA M. BACON, M. D.,
Grand Medical Director of the Degree of Honor of Kansas,
Kansas City, Kansas.

Roentgen or X-Rays are generated in a vacuum tube, presenting a form of energy manifested in its action upon certain unstable chemical compounds, in which it produces chemical changes, and on certain salts, in which it produces a brilliant phosphoresence. The mode of transmission of this energy and its nature are matters of some importance, but of great obscurity. The cathode ray, discovered and named by Crooks, plays a very important part in the production of the X-Ray. It is given off from the cathode, strikes the target of the anode, and is there converted into, and sent forth from the tube as the X-Ray. The cathode rays are visible in a low vacuum tube, giving a blue or purple color. They act similarly to the ultra-violet ray and may be focused or deflected.

There are different theories as to the X-Ray. Some claim they consist of a stream of hydrogen corpuscles, negatively charged, moving about 70,000 miles per second, causing molecular bombardment within a Crook's tube. Others say they are longitudinal vibrations. The generally accepted theory is that the rays are thrown off as particles

*Read before the Kansas Medical Society at its meeting in Topeka, May 7, 8, 9, 1906.

from all highly heated and highly electrified bodies. The X-Rays are invisible, and can not be reflected or refracted and act at site of entrance as well as exit.

The method of administration, dose, and application of the ray must vary with the object to be accomplished and the tolerance of the patient. This requires, as a lawyer would say, skill, care and diligence, based upon clinical knowledge and experience, with eternal vigilance an ever present important factor. There seems to be no fixed rule which one may safely follow in all cases, each being a law unto itself. In view of its decided dangers, it is better to act cautiously, keeping upon the side of safety, even at an increased expense to patient for prolonged treatment. It is the experience of the best operators, that cases, as a rule, do better with daily treatment. The time of exposure may vary from two to fifty minutes, accordng to the condition, reaction and urgency of the case. The patient is carefully protected from the action of the ray with lead, tinfoil, etc., except an area about fifty per cent, larger than the area involved. In mammary cancer, the axilla should always be exposed. A medium or soft tube is preferred for superficial conditions and a high tube for deep seated cases.

The reaction, which is the indication for withholding, or greatly diminishing the strength, consists in a tingling, itching, or burning sensation in the skin, slight erythema, slight turgescence, beginning pigmentation, falling of the hair, or a decided change in its appearance.

The value of the X-Ray as an aid to diagnosis in bone lesions and foreign bodies, needs no mention here. Its use in diagnosis of chest diseases has not received much attention. In several clinics in Europe, an X-Ray examination of the chest is considered as important as the observation of the physical signs.

There is no longer any question regarding the value of the X-Ray in many classes of skin diseases. In lupus vulgaris most brilliant results have been obtained. Of acne, eczema, psoriasis, pruritis, sycosis, mycosis fungoides, senile keratosis, venereal condylomata, thousands of cases have been cured or treated with unusual success. In epithelioma the X-Ray may be classed as a specific cure. The next class of cases most successfully treated is cancer of the breast.

The power of the ray to alleviate the many distressing symptoms, pain, offensive odors, arrest of the progress, destruction and casting off of morbid tissue masses, checking of hemorrhage, with general improvement due to hope born of despair in inoperable cases of malignant disease and our ability to improve otherwise hopeless cases, and in a limited number effect a cure, makes the X-Ray a therapeutic agent,

which should be more generally understood and widely used. The ray seems to exert a selective action on the pathogenic growth, and the process by which it disappears is usually one of drying and shrivelling, rather than of sloughing. The reason for this apparent selective action, while not altogether clear, is probably that the low vitality of the neoplastic tissue as compared with the surrounding healthy tissue, causes it to react more readily than the latter.

In masses which have fallen off following treatment by the X-Ray and have been examined under the microscope, the cancer cells were found destroyed, when before treatment the microscope showed the cells most malignant and the clinical history had been one of rapid growth. The good cosmetic effects, a question of no small consideration, obtained by treatment with the ray is probably due to its stimulating influence upon the tissues. In the treatment of malignant disease, surgery, after being in experimental use for many years, has proven a keen disappointment in thousands of cases, and new operations are being devised, with the earnest advice to send the patients earlier,—never early enough. Yet surgery has its place and if combined with the therapeutic use of the X-Ray, an agent of known power and selective action on the cancer cell a larger percentage of this class of cases will be spared to years of usefulness. Every case operated on for cancer should be subjected to the ray immediately after operation to prevent recurrence and metastasis. The ray also has a field of usefulness in the treatment of malignant disease preliminary to operation, when for any reason it must be delayed. In such cases it would doubtless be possible at times to inhibit the development of the growth and render less dangerous the delay. In exophthalmic goiter, X-radiation has proven very successful. In keloid, the ray gives better results than any other agent and it effects complete disappearance of the growth and its replacement by a smooth white scar. Diffuse keloidal conditions following burns are not so successfully treated. In leukemia, we have in the X-Ray an efficient means of relief and in some cases of apparent cure.

The X-Ray has its dangers as well as uses, and operators should take every precaution to protect themselves against this subtle force. But the experience of the pioneer workers in this field has made it possible to avoid that condition known as X-Ray burn, or other breaking down of healthy tissue from the frequent exposure to the ray.

CHOLECYSTITIS.*

JOHN T. AXTELL, M. D.,
Newton, Kansas.

Cholecystitis is the inflammation of the gall bladder. It may be catarrhal, croupous or suppurative, acute or chronic. It may be associated with cholangitis (or inflammation of the bile ducts). It may tend to obliteration of the gall bladder, to stricture of the gall bladder or of the ducts, to gangrene, to perforation or to fistula. It may or may not result in cholelithiasis (or the formation of gall stones).

It is now almost universally conceded to be an infective disease,—the colon, the typhoid and doubtless many other bacilli being prominent in the list of causative agents. Experiments on animals have shown that aseptic foreign bodies may remain in the gall bladder for an indefinite time without causing inflammation or precipitating the solids of the bile. One observer claims that foreign bodies impregnated with virulent bacteria cause an intense cholecystitis but without calculi. If the bacteria, however, are attenuated calculi will be formed. All agree that stasis of the flow of bile is necessary to cause calculi.

Operations and experiments performed in the last few years have caused us to somewhat modify the older ideas of the bile and its uses. It is probably chiefly excrementitious and like the urine is constantly being formed and cast out—although probably useful in digesting fats it is not necessary. Patients may increase in weight and enjoy perfect health with all the two or three pints of bile secreted in a day poured out on the outside of the body. The bile is but slightly, if at all antiseptic. Investigation shows that the secretion of bile goes on with great regularity and is not influenced materially by diet or by "cholagogues." Patients as a rule are not more constipated when the bile is drained to the outside (so that it does not enter the intestinal canal,) hence the belief in the laxative effect of bile is mistaken. The bile is nine times more poisonous than the urine, hence the importance of draining the gall bladder. The gall bladder is absent in the horse and in some other animals.

A few years ago we depended on finding biliary colic, jaundice and the discovery of gall stones in the feces to make our diagnosis of gall bladder diseases. We now know that more than half the cases have never had biliary colic or jaundice; and in only a very small percentage are calculi found in the feces. The points more to be depended upon

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are digestive disturbances, a dull pain or weight in the right side, and a point of tenderness on pressure between the ninth costal cartilage on the right side and the umbilicus.

If the patient has had typhoid fever or appendicitis the probability is increased. When there is an enlarged gall bladder it is well to remember that it moves with respiration while the kidneys do not do so. The Roentgen ray is not to be depended upon at all in making diagnosis.

Medical treatment has little or no effect. Probably the drinking of large quantities of water is the best medicinal procedure. Doubtless this is why Carlsbad and all other springs are popular. It is generally conceded that calculi do not form unless there is some stasis of the flow of bile. The object of treatment then is summed up in the word drainage. Cholecystomy accomplishes this with a very little danger and with satisfactory results in most cases. Removal of the lining of the gall bladder is better when the organ is greatly atrophied or badly diseased. The treatment is practically the same whether calculi are present or not. They should be considered only incidental (to be removed if present). Drainage is the great desideratum and the operation should always be for "diseased gall bladder"—not for "gall stones."

DISCUSSION.*

DR. HUGHES: I am simply charmed to hear the doctor's paper with regard to intracapsular fracture. It has been my misfortune to come in contact with a considerable number of cases of malignant disease, and I have referred a dozen cases to the X-ray men, and in only one instance have I seen a recovery from malignant disease, and in that case it was called epithelioma of the nose. I have seen cases benefitted and retarded by the use of the X-ray, but I have seen more than the one cured. I have seen a number of cases of carcinoma cured by the use of the knife. I believe it is a good idea to encourage the use of the X-ray in these cases, but I do not think we should lend our voice to the proposition that cancer or sarcoma is curable by X-ray unless the disease is very superficial.

I believe the doctor advances the most modern and advanced thought on the treatment of cholecystitis. I never yet have found a gall bladder with any quantity of pus in it. Inflammation of the gall bladder does not obliterate the gall bladder at times. Upon making an incision in one patient I was astonished to find there was apparently no gall bladder left. The first case of that kind I ever encountered. In the diagnosis of this condition the doctor omitted to mention or associate pain in the right shoulder; in the vast majority of cases of cholecystitis the pain is noticeable in the right shoulder. As in a former paper which was read yesterday, I agree with the author that stone in the gall bladder is the cause of considerable amount of disturbance. In the average case it does not cause very much disturbance. In one remarkable case occuring in the past two weeks in which the patient had a very large gall stone about the size of a small hen's egg, there was no history of pain in the gall bladder, no history of jaundice, but

[*Some of the gentlemen who took part in the discussion have neglected to return their report of the discussion for publication.—EDITOR.]

complaint of pain in the region of the appendix, and within an hour or two of the time I saw the patient, I operated and removed the appendix which was very slightly affected, and in searching around the abdomen for the disturbance I found a hard mass and brought it to the surface, which proved to be a hard substance in the bowels. On making an incision in the bowels the large stone was removed and the intestine sewed up very quickly and I thought safely, anticipating the recovery. The patient died the same night of sepsis. So with that instance we have a good illustration that very large stones are sometimes found, even more than one stone, without any severe symptoms of disease of the gall bladder whatever. As I say, the doctor's paper is modern and I think up to date in every way, although not in accord with the usual thought on the subject of cholecystitis.

Dr. Currie, Sterling: I like Dr. Axtell's paper very much. I believe we should look upon gall stones as a disease as a misnomer. Gall stones are only symptoms. There are never gall stones in the gall bladder without an inflammatory process. We may have an inflammatory process with the gall stones or without. If the patient passes gall stones and we find them in the feces, we know he did have them, but we do not know any more than we did before—whether he has any more or not. We have chronic cholecystitis, and it has been brought out very plainly that medicine does no good at all; then the only plan is to drain. If we operate on a case of appendicitis and do not find a concretion in the appendix, it was formerly thought it should not have been operated upon. We know it makes no difference whether there is a concretion in the appendix or not if there is inflammation the right thing to do is to have an operation. The same thing is true in reference to the gall bladder. We know what the result is if we allow an acute attack of appendicitis to occur; we know the danger of an operation then, and the same thing is true of an operation on the gall bladder, if we wait until the secretions form. With this true, of course the mortality rate would be very different to what it would be if we operated earlier.

I liked the paper on the use of the X-ray. One thing I believe we should all keep in mind, that the X-ray will not cure everything. We are putting too much confidence in it I believe. It should not be used on operable cases. Where the cancerous growth is large it should be removed, and the X-ray treatment should follow the removal. If we commence on the operable cases we will be disappointed in our results; but if it is removed surgically and followed by the X-ray treatment I believe we will accomplish results.

Dr. Latta: In relation to the paper on intra capsular fracture, I am not well up on the literature of the subject. It used to be taught that we might find disastrous results from long confinement of elderly persons in bed. I would like to ask the essayist why that element did not produce trouble. Is it safe to ignore it?

Dr. Bacon: In reply to Dr. Hughes, I will say I believe I made no claim in my paper that the X-ray would cure everything. It is not a "cure all" and it will not cure moribund cases. So far as the deep seated cases are concerned they are not so promising as the superficial ones. I have in mind one case of cancer of the stomach—it had been operated on a number of times, and the tumor was quite as large as my head. That case was sent to the X-ray operator, but there was positively no hope of its ever being cured. I recall a case that was operated on about twelve years ago, and the woman is now under treatment for a recurrence. You can remove the tissue but once and there is nothing more to be done but send the patient to the X-ray operator. Of course time alone will prove the efficacy of the X-ray treatment. While it has proven of undoubted value in many cases and a positive cure in others cases, we cannot tell whether it is permanent or not, but I cannot see why those who have

not taken X-ray treatment are better off to submit to surgery which removes part of the tissue.

Of course it is most successful in the superficial cases. I have in mind a case; there was epithelioma on one side of the face and another right under the eye, which involved the bony structures. Those were put under the microscope and they said they were the same class of cancer, but the general character was not the same and they did not respond to the X-ray in the same way. The one which grew the more rapidly has long ago yielded to the treatment and there is nothing now to show but the slight scar. The other is under process of treatment, and I doubt very much if it will be cured. Why this is I am unable to tell.

The next class of cancer which responds best to the treatment is cancer of the breast. I think it is the custom usually, to advise operation. When these conditions are very much exaggerated it is wise to remove by the knife and then submit the patient to the X-ray treatment. I believe if any X-ray operator would come before you and tell you of some of the cures he has performed, it would meet with incredulity. I remember one cancer of the breast which was four or five inches in diameter, quite a large mass, and it is yielding nicely to the X-ray treatment.

The tumor diminishes in size, the pains decrease,and there is no inconvenience whatever, although there is remaining scar tissue. In superficial cases this drops off; but not in cancer of the breast. In operations there are reported about seventeen per cent of cures and eighty-three per cent that are not cured. In these cases that are cured it is impossible to tell just exactly the character without microscopic examination.

In one case I have in mind, a sarcoma of the neck, the young man was under X-ray treatment for eighteen months and the sarcoma has all disappeared. I saw him about a year after the treatment and he was in very good health.

The X-ray of course has a specific action on the cancer cell; in just what way I am unable to tell, but it evidently destroys the cell. In one case of rapid progress the growth yielded to the X-ray, the tumor fell off enmasse, and the microscope declared there was no cancer cell remaining. It is a stimulant to the healthy cell. The X-ray of course, can reach a cell which no human eye can detect. If the surgeon could ge t all the cancer cells he could cure all these conditions.

Dr. WALKER: In answer to Dr. Latta's question with reference to old people, how is it we keep them in confinement from six to ten weeks without producing any shock, and other sequels such as pneumonia. In the first place that lateral extension applied to intra-capsular fracture relieves almost immediately the pain, so that it takes away the cause of the shock. I do not think the mere fracture of the bone causes the shock, but it is the pain brought about by the constant grinding of the bones brought together.

Again, this plan of treatment I have set forth enables the patient to change posture. You can lift them up into a sitting posture every day if you want to, and you can sponge off the parts and give them rubbings and all those things which help to keep up the vitality, and that accounts for the fact that we can keep these patients in bed as we do with out any great shock or exhaustion.

I have a number of cases in connection with Dr. Maxwell on this line of treatment and I have never seen a case of exhaustion or a case of pneumonia follow this kind of confinement. I have seen it in people of eighty years of age, and the case I reported was seventy-seven years of age, a very large woman, and a case you would think confinement in bed would bring about a great many difficulties; yet in nine weeks she got up from her bed in very good condition physically.

I was glad to know there was one , Dr. Schwartz, who had treated a case after this plan. I would tell the Doctor that it is not a question that is going to die with the au-

thor of this plan of treatment, for I know at the Denver meeting at St. Paul, and again at the meeting in Saratoga it occupied a very important position upon the program of the American Medical Association. It was thoroughly discussed.

It seems the profession have been a long time in seeing the rationality of this treatment. It is the rational treatment. It simply holds the parts in position and the bones will unite.

I am sure that in nearly every town of any size you will find old ladies going around on wheel chairs and on crutches, etc., or with noticeable limps, because of these intracapsular fractures that have not been properly treated.

HYPOPYON KERATITIS.*

A. C. GRAVES, M. D.,
Pittsburg, Kansas.

Hypopyon Keratitis is the name that has been given to the combination of ulcer of the cornea and pus in the anterior chamber. Before going into the causes of inflammation of the cornea, let us take a cursory view of this membrane. The cornea is more exposed to external injuries, than any other portion of the eye ball. It has no blood vessels of its own. Its central zone is quite a distance from the blood vessels, from which it must absorb its nutrition; for this reason when the central zone is injured, or attacked by microbic infection it has less resistance than other portions of the eyeball. In studying the different forms of inflammations of the cornea, I think it best to divide them, into superficial and deep, and I shall place Hypopyon Keratitis, as a subdivision of the deep variety. All inflammations of the cornea are recognized as being of microbic origin, and usually exogenous in type. Microbic infection endogenous in type is very exceptional. The conjunctival sac is supposed to contain infecting microbes all the time, and in greatly increased numbers in those patients that have dacyro-cystitis. The microbes that are usually held responsible, for inflammation in the cornea, are Staphylococcus aureus, staphylococcus albus, pneumococcus, and streptococcus. The epithelium presents an insurmountable barrier to these microbes, and it is necessary for it to be abraded, in some way, before they can gain entrance. When they gain entrance into the cornea, they secrete toxines, which diffuse in every direction through the tissues, and upon reaching the periphery of the cornea, paralyze the pericorneal vessels, and exudation of plasma and leucocytes takes place.

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These are drawn by this substance to the point of infection. In this way an infiltration of the corneal tissue is produced. The infiltrated tissue breaks down, and an abscess is formed. The layer covering the abscess breaks away and an ulcer is formed. Some ulcers have a tendency to spread over the corneal surface, others go deep into it. Some are purulent; others, non-purulent. Some attack by preference the margin of the cornea, others the center. Some will yield to treatment readily, others are almost incurable. Again some ulcerative corneal processes are attended by much circum-corneal injection, severe pain in and about the eye, great reflex blepharospasm, and lachrymation, while others, which may really be more severe processes in so far as the integrity of the eye is concerned, can run their course with scarcely any injection of the eyeball, and with little or no distress to the patient (Swanzy). I will not go into the different steps of an inflammation of the cornea, but will say that the struggle against microbic infection is a function of the migratory cells. I account for these different manifestations by the distinctive manner in which each microbe affects the cornea. It was once the opinion of ophthalmologists that fistulous tracts formed, leading from the ulcer into the anterior chamber. Pus found its way through these fistulous tracts into this chamber and in this way they accounted for its presence there. I find the following statement in Juler, "When the abscess is near the surface, the superficial layers of the cornea break down and form a superficial ulcer. When it is deeply situated, the pointing takes place inwards, and the pus passes into the anterior chamber, It occasionally happens that an abscess opens both outwards and inwards, and so forms a fistulous opening into the anterior chamber." From the investigations lately made I am persuaded that this accounting for pus in the anterior chamber is incorrect, from the fact that microbes are not found in the pus, for the membrane of Descemet will not allow a microbe to pass through it. I cannot help at this point but notice the the protection the eye has against microbic infection. The epithelium, the superficial layer of the cornea, presents an insurmountable barrier to the microbes in the conjunctival sac, and when they gain entrance into the cornea through an abrasion in the epithelium, the membrane of Descemet prevents them from gaining entrance into the anterior chamber I have seen every lamina of the cornea broken down,except the membrane of Descemet, and yet it maintained its integrity, and sustained the intraocular pressure.

Professor Leber accounts for pus in the anterior chamber in the following way: The phlogogenic substances, toxines, produced by pathogenic microbes in deep ulcers of the cornea, diffuse in every direction; if the toxines are sufficiently numerous, they reach the iris,

where they cause the same vascular alteration, exudation of plasma, and emigration of cells,—i. e., iritis. The exudation, especially the cells, may accumulate on the bottom of the anterior chamber under the name of hypopyon.

It is not a difficult matter, to make a diagnosis of hypopyon keratitis, with ulcer in the cornea and pus in the anterior chamber, but sometimes these ulcers will be seen before pus has formed in the anterior chamber. I think it a good plan in the diagnosis of corneal ulcers, to divide them into superficial and deep. The anterior corneal planes, receive their nutrition, in almost the same manner, as the bulbar conjunctiva, while the deeper planes have a nutriment supply, that is more closely allied, to that of the sclera, the iris and the ciliary body (Nuel). We can see from this anatomical arrangement, that diseases that affect the deep corneal planes are likely to affect the iris and ciliary body, so we see the necessity in deciding if the ulcer be superficial or deep. This is sometimes very difficult to determine by mere inspection of the ulcer. In ulcerations of the deeper planes of the cornea, the phlogogenic substance is diffused in every direction and causes a congestion of the iris, so an inspection of this membrane will reveal the gravity of the disease.

The first questions to consider are: Is there a congestion of the iris? Is the pupil sluggish in action? Has the iris lost its beautiful luster and taken on a muddy color? Is there ciliary pain?

Hypopyon keratitis is a very grave disease so far as vision is concerned. This is the disease that produces dense cicatricial tissue, or staphyloma may follow in its wake. In an ulcer we have loss of substance, and in the healing process, this loss must be filled in with connective tissue, and it seems to be a law of nature, for connective tissue to heal in whiter than the original tissue. This should be explained to every patient with ulceration of the cornea that is likely to have cicatricial tissue follow: otherwise, he may think that he has been incorrectly treated. If you will notice, most of the cases of hypopyon will come from the working class, and nine cases out of ten, can be traced to an injury. The ulcer will be centrally located, or lap into the central zone, because it is the most exposed region of the cornea. A dense white opacity called a leucoma will be left. This is why vision is so badly damaged. More dangerous than leucoma is staphyloma. The cornea having been weakened by the deep ulcer, is no longer able to withstand the intraocular pressure, and an anterior staphyloma is formed.

There are many other untoward conditions that are likely to follow, which I shall only mention: Anterior synechia, posterior synechia, (both of these predispose the eye to glaucoma).

In the treatment of hypopyon keratitis,I consider the ulcer the home

of the microbe, and the point from which the plogogenic substances emanate. For this reason I think it necessary to render the ulcer as aseptic as possible. To do this, it is necessary to use an antiseptic, or use the electro-cautery. A deep corneal ulcer, with much infiltration, and pus in anterior chamber, is an indication that the ulcer will rapidly enlarge. The first and imperative thing to do, is to stop the progress of the ulcer, and there is nothing I know of, that will do this so effectually as the electro-cautery. When we burn corneal tissue, cicatricial tissue will follow, the condition we so much dread, but if the progress of the ulcer is not checked, the cicatricial tissue of necessity, will be much more extensive than it would have been, if the cautery had been used. There is a stimulation in this kind of treatment. It usually stops the pain at once, a new action commences in the ulcer, and the whole eye begins to improve. I would not use this line of treatment in every case of hypopyon. I select those that are strongly infected and progressive. I cocainize the eye well, and use only a dull red heat. With a needle at white heat it is easy to destroy more tissue than necessary. Iodine or carbolic acid is good treatment for these ulcers. In using iodine or carbolic acid, it is necessary to dry the ulcer, after having used cocaine, and apply the iodine or carbolic acid to every part, then dry the ulcer again, so there will be none left to run over the cornea. Then wash out the conjunctival sac with a boracic solution. It is necessary to give the interior of the eye some attention. There is always iritis with every case of hypopyon, and it is necessary to dilate the pupil if possible. Atropine sulfate is the best remedy for this purpose, but will do very little good if the anterior chamber is half full of pus, or if there should be posterior synechia, that cannot be broken up. A pressure bandage is always necessary in all cases. The cornea having been weakened by the ulceration, there is great danger of anterior staphyloma. When the natural secretion of the eye is altered by inflammation it may be transformed into a favorable medium for germ life, but in its normal condition the secretion antagonizes bacterial growth. Strong antiseptics diminish the resistance of the eye and render it less likely to ward off germ invasion. For this reason I think the conjunctival sac should be carefully cleansed with a weak solution of bichloride of mercury of 1 to 5000 or 1 to 10,000 and the ulcer touched with a saturated solution of methyl blue or violet, and a solution of atropine to be used four times a day. Hot douches and compresses are often serviceable. For pain phenacetine, or sulphonal, or the tablet of acetanilid and sodium comp. are recommended.

The above treatment will be found very good for the milder cases. I have just finished a case in which there was not a great deal of pus in

anterior chamber, and ulcer did not seem to me to demand the galvanocautery, although it was centrally located; so I cleansed the ulcer with tr. iodine, then washed out the conjunctival sac with a boracic solution. In this case there was a great deal of pain, and I used morphine sulfate hypodermically, but this relieved the pain only for a short time. There was a plustension in this case, and I decided this was the cause of the pain, so I did a paracentesis, not for the purpose of evacuating the pus, but to relieve the tension. The results were all that could be expected, but the small amount of scar tissue left, being centrally located, greatly interferes with vision.

Some recommend the subconjunctival injection of cyanide of mercury. Dr. De Wecker recommends several drops of corrosive sublimate solution of the strength of 1 to 2000 or 1 to 1000 to be injected beneath the conjuntiva after cocainization. Pfluger has shown that substances thus injected really reach the cornea. This line of treatment seems to be founded on rational principles; yet results have been no better than when antiseptics are used in the old way. It is supposed that any change in the normal nutrition of the human tissue, or the deposit of any heterogeneous principle in the tissue, there is produced a phlogogenic substance not unlike that produced by pathogenic microbes (Nuel). So it is possible that injections of strong antiseptic solutions beneath the conjunctiva may have to be taken care of by the migratory cells. While antiseptics will kill microbes, it is not likely they will neutralize the toxines produced by them, so I think the best treatment in cases so severe, as to require the subconjunctival injections, is to use the antiseptic in the ulcer. Iodoform, argyrol, and many other bactericidal remedies bave been recommended. So far I have not had any experience with the serum treatment.

Paracentesis will be demanded in many cases. If the chamber is filled to the lower border of the pupil, I think it would be best to do a paracentesis. The plogogenic substance that poisons the uvea, and causes a collection of pus in anterior chamber, does not always stop with formation of pus in the anterior chamber, but sometimes causes pockets of pus to form in the posterior chamber. This explains why these cases improve so slowly and are benefited by a paracentesis. If the ulcer is very large, the incision of Saemisch may be demanded. The chamber should be emptied as slowly as possible, otherwise, there will be hemorrhage and the patient will experience great pain though the incision may not be felt. It has not been my practice to wash out the anterior chamber with antiseptics, but with normal salt solution. I do a paracentesis with a Von Graefe knife, and I make the incision below the ulcer in the lowest part of the anterior chamber, and in healthy corneal tissue if possible.

DISCUSSION.*

DR. REYNOLDS, Horton, Kan.: I was not paying very strict attention. I was short of sleep last night and I did not hear all the paper. I notice the doctor's reference to the accumulation of what appeared to be pus behind posterior elastic membrane. We have known for a long time that this apparent accumulation does not contain the pus germs, but the corpuscles coming there for some purpose. When you have an actual accumulation of the pus, let it out. There is nothing better than the cautery when properly applied to surface infections.

DR. JAMISON, Wellington: You touched upon the vital point. It has been my experience to have never seen a healthy man with an injury to his cornea that gave me dead leucocytes in the anterior chamber. I think we missed the one point, that there is always want of resistance If a man is in good health those leucocytes will not die in the anterior chamber.

DR. LONGENECKER: Mr. Chairman, this is a very important subject. It probably causes more blindness in middle life than any other affection of the eye. It seems to be found more frequently in persons at middle or past middle life, and is more prevalent in the fall or spring of the year. In my practice most of the cases have occurred in the fall of the year. The worst cases of hypopyon keratitis usually come from an injury to the cornea, as a bruise or laceration, such as might be inflicted by a branch or twig of a tree, or from the impact of a small gravel or other substance flying into the eye.

In these cases the ulcer seems to spread more rapidly, and before we can bring our remedial measures into activity there is danger of breaking down or sloughing and consequent loss of the eye.

We are obliged to depend upon that conservative process of nature known as inflammation which brings to the neighborhood of this affection the fighting agents of the blood. The pathway to the seat of the trouble lies in the conjunctiva surrounding the cornea. If the injury is in the center of the cornea, the blood vessels of the conjunctiva can do little good unless the inflammation is high enough to force the formation of new blood vessels into the cornea. So we welcome the attending inflammation around the cornea. The treatment given by the doctor in his paper is all right. I have no criticism to offer.

The accumulated exudate in the anterior chamber is a different character from the purulent discharge found in the ulcer on the surface in the cornea. If it were of the same character we would in all probability have rapid destruction of the eye.

The question of early paracentesis to evacuate the exudate from the anterior chamber must have to do also with the danger of introducing infection from without. When it becomes necessary though, we must take that risk. It is the only way we have of quickly getting rid of extensive accumulation of exudate within the eye. As has been said in the paper, our main efforts are expended in checking the extension of the ulcer. When the ulcer occurs in the central part of the cornea, remote from the conjunctival blood vessels, it usually spreads very rapidly, and soon affects with infiltrates a wide band of corneal tissue surrounding the ulcer. The cornea at the edge of the ulcer becomes undermined and presents an overhanging edge of corneal itissue. The pockets formed by these overhanging layers of corneal tissue form a splendid place for microorganisms to accummulate and develop.

To get rid of this devitalized tissue, destroy the germs contained in these pockets,

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(The report of this discussion was submitted to every one who participated. All the others neglected or refused to return their copy for publication.——EDITOR.)

and at the same time stimulate the tissues beyond the seat of the ulcer. I know of nothing better than the careful but yet thorough application of the electric cautery.

DR. MAGEE, Topeka: I do not believe we have a paper on the list that is more important than this one which has just been read. The treatment of hypopyon is one with which you have to deal if you have many ulcers of the cornea. As has been well said there is no disease of the eye which destroys more eyes than the ulcer of the cornea. I am inclined to believe that Dr. Reynolds has touched the key note when he questions the diagnosis of this being pus. I am coming to the belief that it is not pus, and only in exceptional cases is it pus. If we have such a thing as sterile pus, if you will allow the use of the name, that is it. I am of the opinion that the anterior chamber ought to be opened in these cases. As has been said by Dr. Longenecker, the danger of infection to the interior of the eye is when you open it. The opening in this case cannot be made sterile. You cannot open such an eye with any degree of safety. The material in there is not doing any harm. I question whether the intra-ocular pressure is sufficient to warrant paracentesis. Just as soon as the ulcerative process has ceased this material will take care of itself. The treatment should be instead of a paracentesis hot moist applications with touching of ulcer with some antiseptic—best indicated by the appearance of the ulcer and general condition of eyeball. This is the plan followed.

Dr. DORSEY, Wichita: I just wish to speak about two or three small things in regard to this condition. In the first place I think that ulcers of the cornea should be treated rationally the same as other infected spots. It is a small infected spot. If we could destroy that infection before it is taken far away, we destroy the disease. Personally I have seldom found it necessary to use the electric cautery. Occasionally I consider it the best thing possible, especially where the infection is intense and you do not know the destructive agent with which to combat it. I have frequently used the carbolic acid treatment and it has value. I frequently use nitric acid, after thoroughly cleansing the wound, and found very beneficial effects. By the use of the electric cautery, if one makes the slightest error with the needle he is likely to do great harm.

The second thing is the use of holocaine instead of cocaine. The tendency cocaine has to loosen the epithelium of the cornea makes me prefer holocaine and holocaine has some antiseptic qualities.

In the case that the doctor spoke of in which he performed a paracentesis, without reference to the hypopyon—by this way I would say that most hypopyons will be absorbed if they do not cover more than one-third of the chamber. In the case where he performed the paracentesis I believe he would have found benefit from the use of dionin, together with very hot applications to the eye. These remedies have frequently given very excellent results with regard to the relief of pain.

DR. GSELL, Wichita: Dr. Graves has covered his subject, I think, very thoroughly. I see oculists differ in the use of their cauteries as surgeons differ in their methods. I have been in the past using glacial acetic acid with beneficial results. I have been rather fortunate in treating what few cases of hypopyon I have had. I have never found it necessary to do a paracentesis. I have had several cases in which I was tempted to do a paracentesis but thought I would wait a little longer, and the hypopyon began to clear up. I believe it is necessary of course to at first stop the ulcerative process.

DR. GRAVES (closing) There seems to be a mistake about the exudation of plasma and cells that are found at the bottom of the anterior chamber under the name of hypopyon. The first speaker on the floor said they were there for a purpose. Accord-

ing to the theory of microbe inflammation the pathogenic microbes produce phlogogenic substances, toxines, these are diffused in every direction, and if sufficiently numerous, may reach the pericorneal vessels and anterior chamber, the pericorneal vessels are paralyzed and an exudation of plasma is provoked and an emigation of leucocytes. This exudation is attracted by these substances to the point of infection and thus corneal infiltration is produced, in this case the leucocytes have a function to perform, to stop the progress of the pothogenic microbe.

Now if the substance first mentioned, toxines, reach the iris, the iritic vessels are paralyzed, and an exudation of plasma and leucocytes are produced, but this exudation cannot reach the point of infection as in the case of the pericorneal vessels, and must lodge in the anterior chamber, from the fact the membrane of Descemet presents a barrier through which they cannot pass so I can not see any function this collection in the anterior chamber has to perform. I do not advise paracentesis in all cases for if there is only a small collection it will be absorbed, but experience has taught if the pus has reached the inferior border of the pupil, the resorption of the pus is no longer possible. Some one recommended nitric acid with which to cauterize the corneal ulcer. I do not consider nitric acid a safe remedy for you cannot control it as you can the galvano cautery.

GANGRENE OF THE SKIN.

Report of a Case.

E. SMITH, M. D.
Lawrence, Kansas.

Hazel H. aet. 19 months. First seen in the early morning of July 13, 1906. She had vomited and had fever during the night, and a convulsion just before I was called; when seen her temperature was 105 degrees in the axila; after this it varied from nearly normal to 103 degrees. About one hour later a diarrhoea set in, with at first copious discharges, followed by evening with severe tenesmus. The tenesmus continued to the end, with slight remissions. There was no blood in the stools. On the morning of the 14th, the mother called my attention to a small blister on the right natis, it was filled with clear serum. It spread rapidly until it covered the right buttock, and extended to the left of the anus; at first the part looked like a red scald, later becoming livid in the center, the livid part growing darker and spreading.

On the morning of the 15th, four blisters came on the back, and one on the thumb of the right hand. The one on the thumb had extended by the next morning, so as to cover the whole hand, and about one fourth of the forearm. The hand was swollen, and the palmer surface was livid. Those on the back spread until they covered a third of the dorsal surface.

At about 11:30 a. m. of the 16th, she again vomited and rapidly failed, and died about 2 p. m.

A PLEA FOR CONSERVATISM IN SURGERY: A NEW METHOD AND A PROPOSED NEW INSTRUMENT FOR TREATING RETROFLEXIONS : REPOSITION AND PACKING.

FRANCES A. HARPER, M. D.
Pittsburg, Kansas.

It has been said that "there is no new thing under the sun." Accepting this statement as true, my only apology or explanation for introducing anything "new" is as follows: I believe that we are too prone to look upon the study of medicine as purely a science,—simply "ascertained truths and facts," instead of making of it an art as well by "the application of knowledge or power to practical purposes." I claim no particular originality in my methods of treatment, excepting in the following out of certain lines or channels which have been indicated or suggested to my mind as being productive of good results in cases heretofore unbenefited by any line of local or medical treatment; lines which have not, to my knowledge, been fully followed out, and which my "inquisitive bump" has led me to investigate for myself; and in the

EXPLANATION OF PLATES.

Plate I. Reposition by manipulation, showing position of uterus in various stages of the process. This was a case of extreme retroflexion with adhesions to rectum, which were broken up only after a month of persistent treatment and manipulation. Cut shows results of seven months of treatment.

Plate II. Principle of Packing for Support. Fig. 1 represents case of simple retroversion. Uterus is made to describe a half circle, and carried over to normal. Figs 2 and 3 illustrate the principle involved in packing for support—the packing serving as "rest" or "brake" as case may be. If displacement is a posterior one, manipulate for reposition by directing force downward upon anterior aspect of cervix, at same time applying a lifting force upwards and forward upon fundus; to hold position gained place cotton roll in anterior fornix. After uterus has passed beyond the midpoint, and is in anteversion, the roll may be placed posterior to cervix. At this stage in many cases the double roll seems to give much satisfaction, and serves as a firm "pessary," holding organ well in place.

Plate III. Fig. 1. cotton roll, ("cotton pessary") Fig. 2. Cone shaped cotton wool tampon, for special medication and counter support Fig. 3: Lamb's wool tampon, used as accessory packing for either medication or support where a specially soft one is desired. Fig. 4. Single-roll "cotton pessary" in situ. Fig. 5. Double-roll "cotton pessary" in situ.

Plate IV.—Faulty but perhaps common method of "plugging" vagina, probably many times aggravating the condition or exaggerating the deformity, instead of overcoming it. (This is a condition very apt to occur following labor from tight bandaging and persistently lying on the back.)

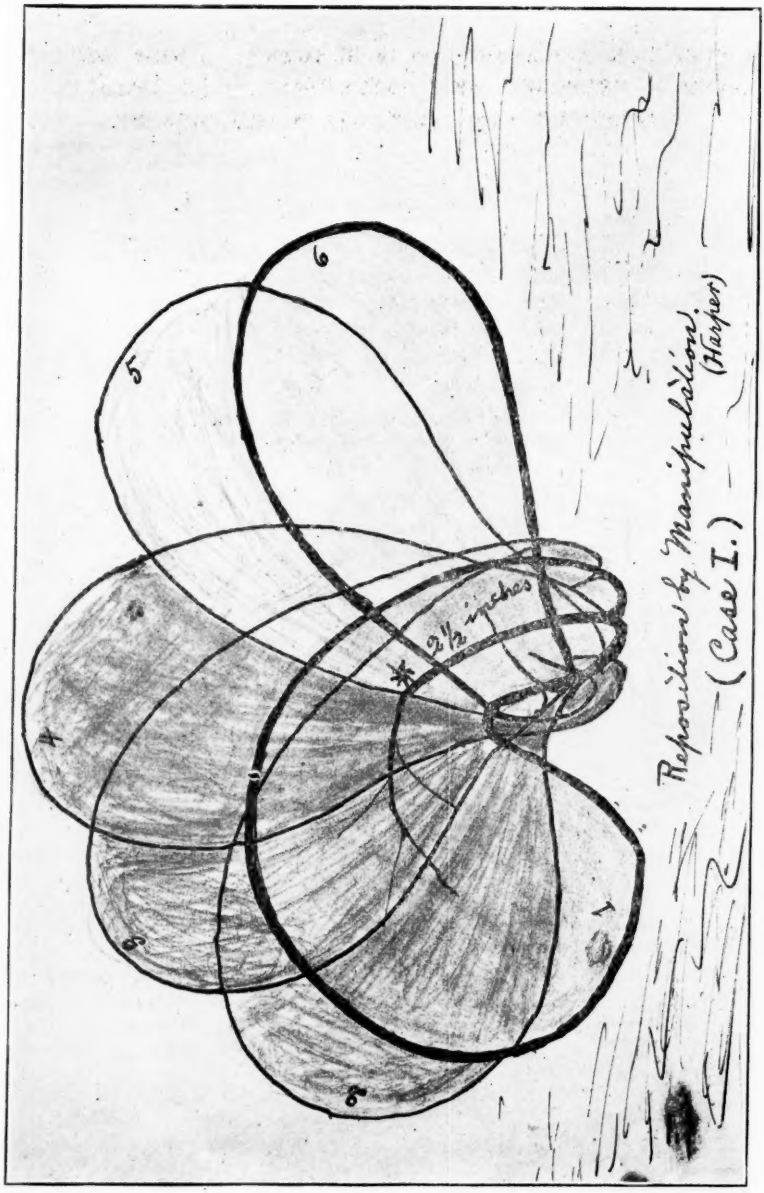


PLATE I.—DR. HARPER.

following out of which I have obliged to forge my own tools,—the only direct evidence possess of a comparatively virgin field.

At best, our medical colleges can only give us the key with which to unlock many of the problems which confront us in the medical world, and it must rest largely with ourselves, individually, whether or not we properly apply the key, or if when the storehouse is opened we recognize what is indicated or unfolded before us.

I look upon radical operations, unless definitely indicated, somewhat as I do upon capital punishment. In condemning a man to death, we take that which we cannot by any means restore. "Life imprisonment" however, gives us the opportunity of giving back to the man that of which he has been temporarily deprived, if we find that an injustice has been done. So it is with surgery in the various chronic ailments of women. How many operations are done which end disastrously, or unsatisfactorily, after which the surgeon asks himself,—"Now, if I had done so-and-so,—or had not done so-and-so, might I not have saved or benefited my patient?" And there always remains a vague doubt in his mind as to whether or not he did just the proper thing; perhaps he operated too soon; perhaps not soon enough; perhaps the patient would have been better without operation at all.

Too many in their zeal to "operate" make a hasty examination,—perhaps seeing the patient for the first time,—advise "an immediate operation," of course; "really cannot tell just how bad the condition is," but wishes "the option of removing whatever organs or parts of organs" which in his best judgment he deems necessary for the well-being of the patient. ("Conservative surgery!" how many sins are committed in thy name!). This sounds all right to the patient; perhaps the surgeon means all right; but it looks too much like condemning a man to death on circumstantial evidence without the formality of a trial! As a rule, however, when a woman has gotten up her courage to visit a surgeon for consultation, she rather expects him to advise operation,—and in order not to disappoint her,—he usually does! I do not wish to be understood as doubting the judgment nor the honesty of all surgeons,—for, God bless them! there are among them some of the noblest men the Lord ever made, and some of the greatest benefactors of the race; neither am I crying down all operations, for many cases are really desperate, and desperate remedies are sometimes necessary; but we cannot help but know that there is a certain class of operators who simply look upon an operation from a monetary standpoint, and as adding one more case to their already long list of "brilliant and successful operations,"—f the patient does die! I once heard a story of an eminent oculist who was demonstrating the straightening of an eye before his class. The ease

PLATE I.—DR. HARPER.

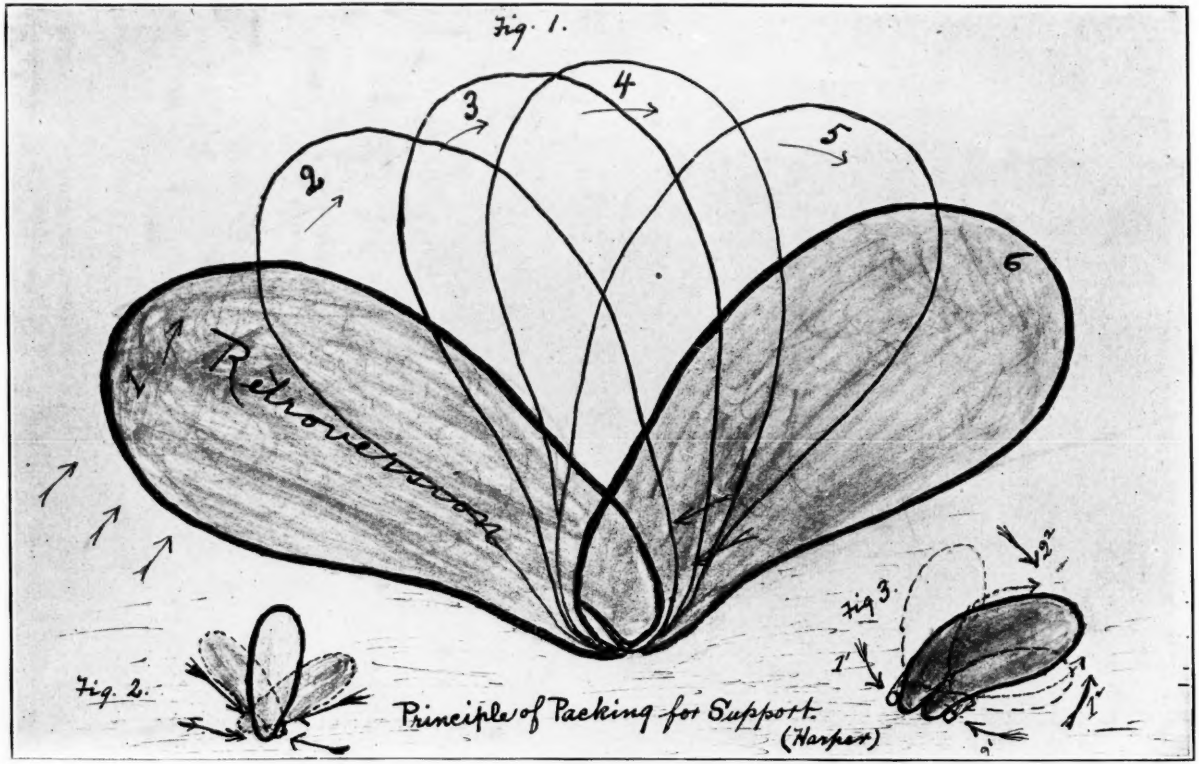


PLATE II.—DR. HARPER.

and dexterity with which he performed the operation occasioned general comment. "Ah, boys," quoth the professor, "you'll have to learn by experience. I spoiled a whole hatful of eyes before I learned to do this!"

In studying over this subject, I have scanned the various articles and discussions in the medical journals, in order to catch if possible the meaning conveyed, or intended to be conveyed, by the term, "conservative surgery," and the views held by operators as to its practicability and merit. I find that many who at first favored the idea, have, after duly observing the results of such conservatism, become more and more in favor of radical operations, and less and less in favor of conservative ones. Why is this? Is it not that we are apt to "place the cart before the horse," and practise our conservatism after operation rather than before? The idea which seems to prevail, with some operators at least, is to open up the abdomen, examine the various organs and appendages, diagnose, determine degree of involvement, treat or excise such organs or parts as are deemed necessary or advisable at the time, —close wound, with idea of perhaps following later with a "secondary" operation. (I recently heard of a case which had been operated upon seven times for the same trouble, and an eighth operation was contemplated! This is as bad as the woman who was subjected to ovariotomy five times, and the man who had his appendix removed three times!) Exploratory incisions are sometimes necessary to clear up doubtful diagnoses, but altogether too many "exploratory incisions" as well as experimental excisions, are made for the purpose of diagnosis, which would better have been made by external observation and treatment,—following later with operation, if necessary, after the subsidence of many obscure and misleading symptoms; then go in with some well defined purpose in view.

Conservative surgery is defined as **"surgery which looks to the preservation or restoration of disabled parts, rather** than their removal." Broadly speaking, it means that we should **use** and **exhaust** every rational means in our power to restore a part; failing with these, we call to our aid surgical means to do what in our best judgment and reasoning non-surgical measures will not do,—**cannot do.** This makes of a radical operation a conservative one. This is true conservatism in surgery, or "conservative surgery," as I understand it.

The full blame, however, for too many and too radical operations cannot wholly be laid at the door of the surgeon, for ofttimes he must take our diagnoses and comes to our rescue in cases which we as general medical practitioners have ineffectually and indifferently treated for months, and perhaps years. Are we wholly blameless, if operation fails? Did we **exhaust** every known means to relieve or to cure our pa-

PLATE II.—DR. HARPER.

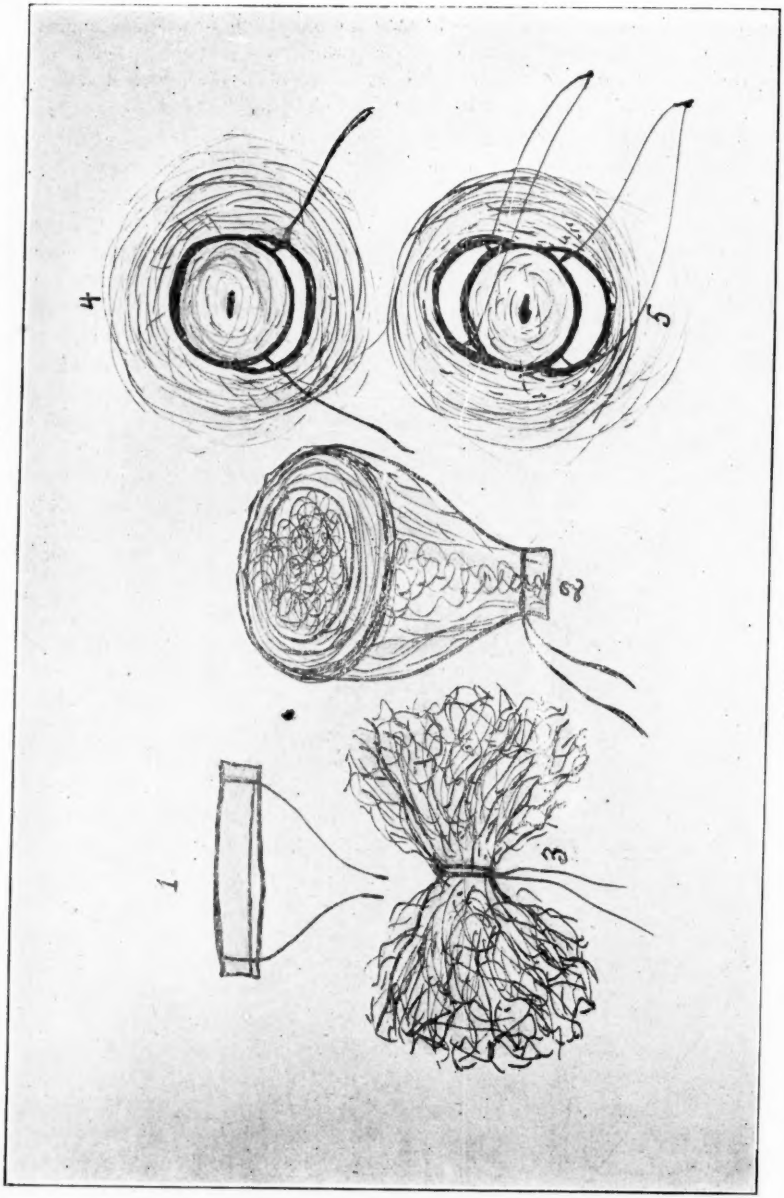


PLATE III.—DR. HARPER.

tient before we admitted our defeat and recognized the fact that "an operation would be necessary to clear up the condition?" Or did we treat the case lightly, diagnosing it as **"female trouble,"** and considering it of no special consequence,—making an occasional superficial examination, and giving an occasional "treatment,"—dosing for various symptoms, and masking the real condition of things by an occasional dose of codeine or other opiate,—tiding her over her many paroxysms and soothing her into the belief that she was improving,—but never really finding out her real trouble, nor being able to intelligently cope with the situation,—till finally we awoke to the fact that our "treatments" had been in vain. and were glad to share our responsibility with the surgeon. After such results, is it any wonder that people in general,—both profession and laity,—have about lost faith in "local treatment"? The probabilities are that the "treatments" were given at irregular intervals, with no definite idea as to the effect, other than to act as a sort of soothing "poultice" for the time. Perhaps they did the patient no special harm,—if treatments were not too often repeated. Possibly they did some good if case was not of too long standing; but the probabilities are that we had all the time been exaggerating the condition or increasing the deformity which we vaguely hoped might be overcome,—and the organ finally becomes so firmly fixed in its malposition that there is little hope of relief, excepting from the knife. (See plate IV). We have been treating a deformity without first reducing it, putting a soothing application on a dislocated or broken limb, in the vain hope that nature will do the rest. Nature will almost work miracles, but she cannot overcome impossibilities. There are certain well established rules to be followed out in the treatment of deformities,— and our rules of surgery are applicable here,—that first we must reduce the deformity, and next, fix the organ or part in correct position, that nature may do her work unhampered. This leads up to a consideration of methods of reposition **and packing** in the treatment of retroflexions.

In order to avoid needless and exhaustive detail and explanation I shall confine myself to a consideration of retroflexions only as that is the deformity in which I first used the method, and for which the proposed instrument was devised. By varying or reversing the method, the instrument, as well as the principle of reposition and packing, may be applied to the various other malpositions with equally good effect.

Reposition is the returning of an organ to its normal position. This is a comparatively simple process with acute or recent cases, but in those long-standing ones of subinvolution with retroflection and adhesions, it must necessarily be a slow and gradual one. Our ability to replace the organ depends largely upon the character of the adhesions,

PLATE III.—DR. HARPER.

PLATE IV.—DR. HARPER.

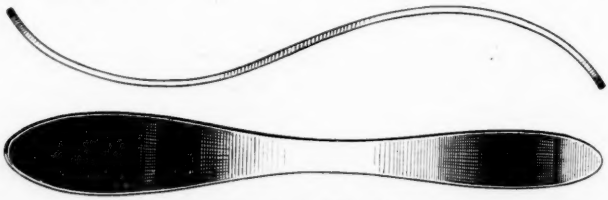
the etiology and chronicity of the case, and co-operation on the part of the patient,—but it is simply wonderful how an apparently immovable organ can be softened and loosened up by proper manipulation, immediately followed by packing, for support and local medication. Many times an apparently firmly bound-down uterus will respond readily to this treatment, but probably the actual adhesions were not as massive as they first appeared, the organ having been held down by being caught under the uterine ligaments. This is probably a somewhat common occurrence in subinvolution with elongated and subinvoluted ligaments. The cuts shown will indicate and explain the principles involved in this method of reposition and packing for support better than any verbal description could do.

The mechanism of this method is the adaption and application of truly scientific principles to practical purposes. The principle of the lever is a scientific fact. A lever of the first class class is a simple contrivance, and easily understood, with fulcrum between power and resistance. This is the foundation principle of our treatments.

Given a case of retroflexion; patient in dorsal position; a firm cotton roll, saturated with hamamelis and boroglycerid is introduced through the speculum and placed at right angles to body in posterior fornix, and pressed firmly into place. The roll is our fulcrum. Now, to lift the load (body of uterus) force is directed downward upon **anterior** aspect of cervix, and to straighten out flexion and assist in the lifting of the load, we also apply a lifting force, upward and against posterior aspect of body of uterus; this latter force being best applied through rectum, from which vantage ground the entire organ and appendages may be easily palpated and definitely located. However, in the dorsal position we are working at a disadvantage,—**working against gravity**, which tends to hold the fundus downward and backward in the pelvic basin. Now change roll to **anterior** fornix. **After the roll is properly adjusted in the anterior fornix**, speculum may be removed, and patient changed to the knee chest position. We have now reversed the order of things,—air rushes in and distends the vagina, greatly aiding us in reposition, and instead of working **against, we assist gravity** in carrying fundus forward. With one hand operating through rectum, and the other over abdomen or within vagina, the position is easily controlled and manipulation made easy; and this roll, which acts as our fulcrum, will later on serve as our "rest" or support in holding position gained. However, as the uterus is carried forward it soon gets beyond the palpating finger in the rectum, and we are hampered in our efforts at reducing flexion and effectually massaging and reducing irregularities in posterior aspect of fundus. This is the rock against

PLATE IV.—DR. HARPER.

which I struck. The finger is a most sensitive, effective and intelligent instrument in such cases, as far as it goes, but an instrument which would give a firmer, broader and more even pressure, and farther reach in all directions, was certainly something to be desired. After many ineffectual attempts to procure something which might answer the purpose, and using various makeshifts, the plan of the new instrument was worked out, and my only apology for it is that **"Necessity is the mother of invention."**



Uterine Repositor, (Harper) ½ size.

Reposition for a retroversion would be a more simple application of the lever principle. (See Plate II.) Just imagine the organ in retroversion, **moving as a whole**, and poised in such manner as to move upon a central pivot, and describing a circle. Slight force applied downward to an anterior aspect of cervix would send it spinning over to anterior position. In a case of retroflexion the mechanism is necessarily more complicated, as we are rotating the organ on a central axis, and at the same time overcoming flexion, thus making the process a slower and more tedious one.

Well, thus far the plan seems all right, and simple, and easy to follow, but, **"but,"** the next thing is to hold organ in place after such reposition. To go back to our surgical principles,—a deformity must first be overcome or reduced; and next, held in position until repair is complete. The uterus is a very mobile organ, having no really fixed position, consequently it is very difficult to "splint" or "fix" satisfactorily. Those to whom I have broached this subject, have, with one accord, expressed themselves as being very sceptical as to our ability to hold the correct position, even after replacement. Did you ever see a man driving up a long, steep hill with a heavily loaded wagon? He stops a number of times to rest his team. What does he do each time he stops? He **blocks the wheels!** That is just exactly the principle upon which we must work; at each treatment **we must block the wheels** if we expect ever to get to the top of the hill with our load. To carry this further,—when the man gets to the top of the hill and starts down the other side **he applies the brakes! So must we!** After the uterus has been carried

forward past the mid-point, or **"danger point"** as Ashton calls it, our packing must be so modified as to serve as a sort of "brake," rather than a "rest" on an up-hill grade. It will be seen from the above homely application of the principle of reposition and packing for support, that it is not simply a theory, but is eminently practical and easy of application.

The following will illustrate plan of treatment:

1. To reduce a **posterior displacement**, use knee-chest position, packing for support(or manipulation) in **anterior** fornix.

2. To reduce an **anterior** displacement, use dorsal position, packing for support (or manipulation) in **posterior fornix**.

If we definitely diagnose the malposition, and correctly make application of the principles above outlined, **we are bound to get results,** in spite of ourselves.

In packing for support, I use what I call my "cotton pessary," a tightly rolled piece of absorbent cotton, of such size as suits the case, and tied at each end with a cord, leaving the two ends of cord separate to aid in adjustment of roll, after which they may be tied together to form a loop. (See Plate III.) The single roll may be used for definite action and support, or double roll if slight but firm opposing action is desired,—one giving **active,** the other **passive** support, depending upon position of fundus. Now, for special medication and gentle counter-support, a cotton wool, or pure lambs wool tampon is introduced through speculum, saturated with whatever medicine may be required for the case, which serves as a soft bed upon which cervix rests. Always bearing in mind our fundamental principles underlying **reposition** and **packing for support,** we may reverse and modify method to suit any malposition which might arise.

Another thing worthy of mention here: In nearly all pelvic displacements there is also a general relaxation of the abdominal walls, which calls for effective support, if best results are to be expected. The ordinary corset is a discomfort, a detriment, and worse than useless. I have had the best results by having the patient wear a "hygienic" straight-front,**front-laced** corset, thus relieving the viscera of the uncomfortable and injurious pressure from the ordinary stiff front steels, and holding the body easily in correct anatomical position, giving firm pressure and easy support just where needed.

I have purposely avoided the topic of general medication and treatment, as well as special medication for local application, as this article was originally intended to deal only with the mechanical principles involved in treating retroflexions by reposition and packing. Nevertheless I feel that to dismiss the subject thus would be irrational and perhaps somewhat misleading, and as incomplete as would be an article

which treated of general systemic medication alone for these conditions. Someone remarked to me not long ago,—"I think we are apt to promise our patients too much from **local treatment alone.**" Yes, and another man actually promises to **cure with systemic remedies alone!** One is just about as rational as the other,—as reasonable as the Christian Scientist who gives the "absent treatment" for everything from a burn up to diphtheria! They may all get results,—**but what results!**

The rational treatment in retroflexions, and diseases of women in general, **is to treat the woman in general,** as well as **specially.** Every organ or system of organs should be systematically interrogated, and so tone up and build up the **woman as a whole,** by every means within our power. Nature is our sheet anchor and our aim should be to so conserve her forces and treat as to her aid in carrying out her reparative work without undue loss of energy.

With definite aim in view, and intelligently applied, electricity, vibratory massage, baths, douches, etc., etc., work much good, while general and special treatment systemic medication, and local applications and treatments are necessary. A regular routine course of treatment should be instituted if we expect to secure good results, and the co-operation of the patient must be secured in regard to the care of herself in the interval between treatments. This latter is a matter not always easy of control, for after suffering for months, perhaps, almost as soon as the load is lifted, pain and pressure symptoms subside, and the woman feels so much better that she thinks she is about well, and the first thing you know she is **"taking in washing"** or doing her own housecleaning,—with a "backset" to overcome as a consequence.

We need to broaden out in our methods of treatment in these diseases,—both medicinally and surgically. The intelligent, thoughtful and unprejudiced medical practitioner or surgeon will bring to his aid and the relief of his patient, every rational means within his power, irrespective of **"cult,"** or **"path."** A happy combination of such general and local measures is bound to bring us to and our patients the happiest results, while the use of half measures will as surely bring disappointment.

In conclusion the subject of medical gynecology is one which should merit our earnest and thoughtful consideration. The indifferent results generally obtained from "treatment" (?) utterly discouraged me at one time, as it has many others, and I decided either to give up such efforts entirely, or to find some rational method whereby some definite results might be secured. Now, comparing results of this method herein outlined with previous indifferent and unsatisfactory ones, I am so convinced of its value, that were I obliged to resume the old way again, I would feel like making no attempt whatever in this line of work.

CASE REPORTS.

CASE I,—2—para; menstrual trouble and indefinite symptoms date back to a month or two after marriage; became pregnant about a year and a half later. Recovered somewhat slowly after first labor; after getting up suffered from prolapse and almost constant "bearing down" feeling. However became pregnant again within a year, and was delivered at term of a fine big healthy boy, who is now four years old. Again a tardy recovery,—if "recovery" it could be called; being on feet brought uterus down even worse than at previous confinement, until life became a burden. Her physician instructed her to "go to bed and stay there," and he could cure her, although he had never once made an examination to determine her real condition, but told her if she would stay in bed long enough the parts would go back. Well, gradually the prolapsed organ did go back and stayed back, and she thought of course, she must be better—or ought to be—as it did not come down any more, but she really felt worse, why, she could not tell, a great weight seemed to pull at her down at her back, which was never free from pain, and there seemed a great mass of something in the rectum, which urged the bowels to move, but really obstructed them, causing great pain at each action, until finally they moved only when urged by an enema or some purgative. For over three years she was "treated" at long range, taking medicine almost continually, to no effect, symptoms all the time growing in intensity; menstrual periods recurred every three weeks, scantily, often accompanied by convulsions, dysmenorrhea being so intense as to confine her in bed for several days at each recurrence. Having grown so progressively worse, in desperation she came to see me, not with any definite idea of getting relief by any treatment, but that she must talk freely to someone, and "tell her troubles." She had not had a good night's rest for months—she could not tell when—and for a week had hardly slept at all, as she could lie in no position to be comfortable. She breathed in short gasping breaths, and every breath she drew was a pain; was very nervous and weak, and had to be brought to the office; countenance anxious and drawn with pain.

Examination was specially difficult, the abdomen being very much bloated and exceedingly sensitive to the touch. Uterus and adnexa a great, hard, corrugated, pulsating mass, lying flexed upon rectum, and excruciatingly painful. The flexure between cervix and fundus was most marked, the latter being firmly bound by adhesions, and immovable; cervix much elongated, and of a dead white, or greyish hue, looking and feeling like cartilage or tendon; os and cervix patulous up to flexure, admitting little finger as far as internal os, probe passing easily on to bend, to which point it measured two and one half inches. Parts were entirely without tone and relaxed.

Frankly, I felt that I was up against a hard proposition and had very little hope of doing anything more than to perhaps make her somewhat more comfortable and get her into a more favorable condition for operative measures when they should be decided upon; an operation for relief at this time could have been nothing short of a most radical one. Treatment was commenced, every other day at first, the first manipulation being directed toward straightening the canal, with the result that in about two weeks the menstrual flow came on more profusely and with less pain than she had experienced for years. However, very little impression seemed to have been made upon adhesions, as uterus remained firm in its malposition, until the end of the first month of persistent manipulation and treatment—when, lo, adhesion seemed to "let go" and the organ went forward with a perceptible "flop!" I need not go into details in regard to encouraging and discouraging features of this case, but at least it grew no worse. Gradually various improvements were noted, as general systemic conditions were improved: the uterus

decreased in size and settled down into a definite position instead of persisting in "flopping about" with every step or movement of the body, and patient gradually became unconscious of the existence of such an organ. Two months and a half of treatment got patient into somewhat more comfortable condition. At the end of this time I went east for six weeks, during which time she continued her home treatments of baths, douches, etc. Upon my return I was much gratified to find conditions no worse. One feature, however, I still observed, which did not encourage me, and that was the relaxed, elongated, patulous cervix, of that dead white hue and cartilaginous feel and look. The organ was freely moveable and packed well, but it still lacked tone. Treatment was resumed, packing being removed only a few hours before next treatment to allow for cleansing douche. Slowly and gradually the pink began to come to cervix—it began to look alive--and that cartilaginous feel began to soften down, and os become less patulous. I felt that we were gaining ground. And we have gained ground ever since steadily. During all these months of treatment uterus has been markedly displaced backwards but once, and that was due to over-exertion. One day, feeling unusually well, patient decided to do her own sweeping, instead of waiting for some one to do it for her. She swept several thick carpets, dusted, and the various et caeteras of a general house-cleaning,with a return of her old pain and pressure symptoms, which she was unable to relieve by douching or any position which she might assume. After a sleepless night she came in for treatment. Uterus was found much swollen and tender, and lying flexed upon rectum. Slight manipulation in knee-chest position replaced the organ, bringing immediate relief, since which time there has been no recurrence of the displacement. Today this patient is rosy, plump and fresh looking—talks with a ring to her voice, walks with a spring to her tread, and the outlook for giving the surgeon a job—is bad for the surgeon! She says she is willing to take treatments five years longer—and keep her anatomy all together, if it be necessary.

This case has been an especially interesting—a most vitally interesting one to me, as demonstrating the method of treatment which I have outlined and used. If this method of treatment has done so much for a case of such gravity and chronicity, what are the possibilities of such treatment in cases of less chronic nature—those cases which visit the average doctor's office month after month and year after year, vainly seeking for aid, and later on turning to the surgeon for the hoped-for relief?

CASE II will illustrate the opposite extreme. Case of subinvolution with marked retroflexion following abortion; four months standing. Symptoms were acute, constant pain and pressure symptoms, growing progressively worse; pulse 120; temperature 101.6, abdominal tenderness and swelling. My better judgment suggested a curetment as a preliminary, but this sounded too much like "operation" and patient would not hear to it. The first great relief, which was remarked after first treatment, was the lifting of the weight and aching from back by raising fundus from rectum and relieving stretch on ligaments; the next was relief from the dysmenorrhoea from straightening the canal. Aseptic and antiseptic treatment, both local and systemic, cleared up her trouble like magic, pressure symptoms and pain not returning after second or third treatment. Menstrual period recurred, free and somewhat prolonged, and absolutely painless, producing sensation of relief and well being, instead of former "dragged out" feeling, a regular nature's curettement. This case was treated one month.

CASE III.—Young woman of 20. One baby 18 months old. Had always the best of health up to four months ago, when she aborted at 2½ months. Did not go to bed, but remained up and about the house. Had flowed almost continually all this time—at times amounting to a flooding, when discharge would be a bright red; at other times black looking and very offensive, coming in shreds and clots. Had done nothing in par-

ticular, but taken the varied advice of friends, until finally uterus dropped down and she suffered constant bearing-down feeling and pain in back. She came in for treatment. Uterus prolapsed, cervix being almost on a level with vaginal opening; fundus enlarged and nodular; right ovary and tube enlarged, hardened and adherent, and exceedingly sensitive to the touch, fundus being considerably drawn to right side; offensive, purulent discharge, streaked with blood. Almost constant headache, slight temperature, sallow skin, coated tongue—everything pointed to septic trouble. Another case in which curetment seemed first indication, to which she strongly objected. (I am learning that in many of these cases nature attains this end more easily and safely than we can, if we but produce favorable conditions for free drainage by proper manipulations in the right direction, dilating and straightening canal, and packing and holding organ in correct position). At the end of a week the offensive discharge had ceased. In about two weeks free, natural menstrual flow came on, bringing away considerable debris, but without offensive odor, and lasting about four days. After this canal was kept well dilated and free to drain for a time, with a rapid shrinking and softening of fundus. Now at the end of five weeks' treatment, uterus is in good position and condition, and right ovary and tube rapidly assuming a normal feel—soreness almost entirely gone. A very few more weeks of this improvement will take her out of my hands.

Case IV. Young primipara, 20 years, baby four months old, fat, good natured and healthy. Somewhat difficult labor with slow recovery, accompanied by hysteria, convulsions, and various nervous manifestations—merging into mania. At times was unsafe to leave alone with her baby, as she felt uncontrollable desire to crush it or do it bodily harm. Was treated locally for about six weeks after birth of her child, and discharged as well, but various nervous symptoms persisted. They moved to Pittsburg, and husband brought her in to me for advice and medicine. She presented the appearance of one mentally unbalanced—wild-eyed, nervous, and started at every sound; hands, feet and head constantly moving and twitching. She had suffered from constant pain and pressure in top and back of head ever since confinement. She insisted that she had no uterine trouble, whatever, that the doctor who had treated her told her that she was all right there, and only needed to go to work to throw off her nervousness. She refused to be examined, and only wanted some medicine "to cure her nervousness." Advised her that a thorough examination would be necessary to definitely locate her trouble, and probably would require a regular course of persistent treatment to remove it. She would not decide about it until later, so medicine was prescribed to perhaps relieve her for a time—which it did. She came in three or four weeks later for examination and treatment. External and internal genital organs in a hyper-sensitive condition; enlarged and hardened uterus lying flexed upon rectum; sensitive areas along spine—particularly at base of brain, between shoulders, and in sacral region; two very sensitive spots immediately above waist line on either side, just at exit of nerves. Treatment was commenced, the first move being the lifting of the uterus and packing it in correct position, relief being experienced from first treatment and she remarked the pressure lessened. The fourth time she came in for treatment she remarked, "I don't have headaches any more." She has now been under treatment a little over two weeks and she really sees and feels that she is getting better every day. She can sit quietly and says she feels "let-down" instead of "keyed up to a high tension" as she had felt so long, and has entirely lost the feeling that she must crush her baby when caring for it. Local treatment for the uterine condition and electrical and vibratory massage and heat, tonics, nervines, etc., and her home treatment of bathing and douching, with her walk of a mile every other day to take her treatment are working wonders for her—are keeping her mind occupied and busy.

CASE V. Married woman of 32; 2-para,—oldest child 12, youngest, 8 years old; trouble dates back to birth of first. Has taken local treatments—months at a time—for years, from various physicians. Eight years ago was advised that the only way to cure her was to have ovaries removed; however refused operation. After having been treated intermittently all these years, and being given up as an operative case, she visited a surgeon who advised an immediate operation; he really could not tell just how bad the condition was, but desired "the option of removing whatever organs or parts" he should deem necessary at the time of the operation. However, her husband absolutely refused to have her "cut up," as he expressed it. She presented herself for examination and treatment. Considerable gastro-intestinal distension, with eructations; abdominal tenderness. Region of umbilicus sensitive and depressed, and feeling as if firmly adherent to internal parts; she complained of its feeling as if some weight pulled it down and back, which described direction of pain and aching in back and sacral region. Large and nodular varicosities in right limb, extending from ankle to about six inches above the knee, which stood out in great knotted cords when standing. Bowels particularly sluggish, and difficult to move. Uterus enlarged, hardened and sensitive to the touch, and lying flexed on rectum. Manipulation in knee chest position carried uterus well forward, demonstrating that adhesions were light or absent. This case has not been under treatment long enough to demonstrate what may be done for it, but it has responded well to treatment thus far, and with the full cooperation of the patient I do not feel at all dubious over prospective results—especially after obtaining such results from treatment in Case I.

I might merely mention five other cases taken at random from record book which were under treatment all the way from three weeks to four months; two resulting from abortions, and three from labor at term. In only one case did I find it necessary to curet to get rid of adherent secundines. All have made uneventful recovery. The causes, conditions and general symptoms in these cases were practically the same—resulting in subinvolution with retrodisplacement, a most prolific cause (I might say the most prolific) of surgical interference in diseases of women—a condition apparently little understood and unintelligently handled by the general practitioner, and which, from sheer force of habit is delegated to the surgeon.

The Third Congress of Climatotherapy and Urban Hygiene will hold its meeting, during the Easter vacation, 1907, on the French Riveria (that part between Hyeres and the Italian frontier) and in Corsica.

The sessions will be held at Cannes, Monaco, Mentone, and Ajaccio; but all the towns and stations on the Mediterranean Littoral are included in the program:—Cannes, Nice, Monte-Carlo, Mentone, Hyeres, Antibes, Grasse, St. Raphael, Juan-les-Pins, Beaulieu, Cap Martin Thorence, etc.

The congress will last about one week on the French coast and will finish in Corsica.

The Military Surgeon is the new name for the Journal of the Association of Military Surgeons. Major James Evelyn Pilcher is the editor and has shown great energy in building up and modernizing the journal. It is published at Carlisle, Penn.

Correspondence.

Newspaper Advertising.

To the Editor:

It is evident that the advertisement question is being generally considered by the profession. Lately the JOURNAL has given us samples that are not altogether creditable to the profession. Physicians are actuated by the same impulses that business men are and are seeking to extend their patronage. In the November JOURNAL on page 500 you intimate that the code is too strict. You state a space you believe a physician might be allowed to occupy in a newspaper and suggest a form he might use and keep within the requirements of the code. If the form suggested would tell the truth about the man who used it, no one ought to object. Neither ought one to object if one used an entire page to inform the public of his location, etc., always providing he conformed to the truth and paid the printer. Why should one inch in a paper be ethical? Why should a column make the man a quack who used it, if the same words occured in each? The simple legend, Dr. John Smith, Physician and Surgeon, which appears in nearly every paper in Kansas, is often half untrue, and occasionally wholly so. The legend should read "Dr. John Smith, pill peddlar," to be true. But Dr. John Smith observes the traditional form, and is therefore ethical. If he were bright, an intelligent prescriber, and a competent surgeon, and said so, in a double column next to reading matter, he would be a quack. That is about the attitude of the devotees of the code.

Many of our brightest men were advertisers in their early career. I could name a score. So can you. It is strange, but a physician may own a drug store, and send out his name over advertisements for Doane's Kidney Pills, Lydia Pinkham's Remedies, and Peruna, and be ethical. He can even own and advertise a cafe, a livery stable or a dairy and remain in good standing. But if he invests in a good office equipment and puts a clean stock of drugs in his office, and then advertises these facts to the people of his community, he becomes a quack. Strange, is it not, that it is quackery to advertise the fact that one has taken a post graduate course, or has equipped his office and is able to treat diseases well, but that it is ethical to advertise Doane's pills from the ground floor room below the office. In the sense of earning a livelihood practicing medicine is a business. It ought to be a business where one engaged

in it would seek to invest at least a part of his surplus. Physicians seek outside investments because the code forbids them to give the publicity to the medical investments, which would make them pay. Advertising is not a crime. Deception, misrepresentation and back-biting are, or ought to be. You tell how the Iola physicians were forced to use the papers to inform the public about the hospital matter. Dr. Sutcliffe is not the only sham that needs the sunlight of publicity. There are a few others in the regular profession that might require the purge of printers ink to make and keep them clean. The profession ought to awake to the value of printers ink. The Christian Scientist understands its value. Every county society should buy newspaper space and expose the shams in and out of the profession fearlessly and truthfully. We need the press on our side. The editors want to be with us but the quack and patent medicine men are the ones that spend the money in advertising. How can an editor go back on the man that pays the rent, and spend time and space in the interests of the men who are resolving that he shall not even mention their names in his pape.?

If one half the money spent by such people as Peruna, Dr. Bye, etc., was spent by the profession, to impart needed knowledge to the people and correct the wrong impressions that gain currency, the press, or the decent part of it, and that is at least nine tenths, would be only too glad to drop the patent medicine advertisements.

If osteopathy had been investigated thoroughly ten or twelve years ago, its cures and failures published side by side its good points and pretentions stated fairly and fully we would have little trouble with its votaries now. If a quack doctor were done thoroughly in every paper in Kansas, and testimonials from his dissatisfied dupes published, he would soon find his victims few. If the analysis of Peruna and Hostetter's Bitters had been common property of the papers and the people years ago, Colliers Weekly would not have found it necessary to publish the Great America Fraud Series. The people don't half appreciate the value of physicians. They ought to be told. If we are not appreciated it is our own fault. Irregulars and pretenders have discredited us and we have held our peace. Quacks and charlatans have called themselves by our names and we have been dumb. Patent medicines have claimed cures where we have failed, and we have remained silent. How are the people to know that we are not of the same stripe as the quack? How can they know that the patent medicine claims are false?

Let us start on a campaign of publicity and let it be without malice but thorough. Let fraud be exposed even if some of our pillars of strength are destroyed. Let us purge our ranks and deserve the confidence of our patients and we will have it. A campaign of education

would direct hundreds of thousands of dollars from the coffers of medicine companies and quacks into the pockets of the physicians and the people be the better for the diversion. Publicity would make the advertiser careful of what he said to the people, and as exposure of the false claims would follow speedily, he would find any but truthful statements unprofitable. Then the spirit of the code would be observed as violation would not be wise or profitable.

A FOLLOWER OF CARLYLE.

[Editor's note: We would reiterate that the medical profession must be guided by the dictates of dignity and taste in all its dealings. A full page advertisement would violate both taste and dignity. If an announcement of the location of a newcomer be needful, then it should be as quiet and dignified as possible. Each county and locality must decide what its own conditions make necessary, and should not hesitate to use the newspapers if the occasion demands it; but such use should be restricted to that absolutely necessary. For it is a fact that the solid men, the men that amount to something in the long run, are the ones who are least heard of in an advertising campaign.]

Albuminuria:

To the Editor:

Twenty-five years ago I was a resident of Kansas and for many years past I have watched with interest the rapid development of the state.

The progress in medicine in Kansas has been phenomenal. No journal of any State Medical Society is more up to date than the Journal of the Kansas Medical Society. I was especially interested in the last (December) number.

Dr. John G. Sheldon's article on "The Significance of Sugar in the Urine in Surgical Patients," is timely and of great value. I wish, however, he had dwelt more upon the glycosuria and acidosic conditions resulting from traumatism.

It was very early recognized that traumatism produced profound metabolic changes, even when applied surgically. To one of the surgical consequences Dupuytren applied sixty years ago the term delirium traumaticum nervosum.

The relationship shown in the alternation of diabetes with the psychosis threw some light on the underlying element of this delirium traumaticum nervosum, as also did the relation of gout and rheumatism similarly with like nervous and psychic states.

It is known that even the slightest traumatism, surgical or otherwise, may be accompanied with glycosuria and acidosis. Coriat has shown that all the depressed states are accompanied with acidosic conditions, which are the product of suboxidation that follows depression and continues it. The same factors following surgical operations have been recently observed by J. A. Kelly.

That traumatism arising from accidents may produce glycosuria and allied states has recently been legally decided in London.

Previous to and after every surgical operation careful uranalyses should be made. Uranalysis in surgical cases tends to indicate that the constitutional effect of operations is along the line of interference with oxidation, and that many of the cardiac strains are really due to increased arterial tension, arising from maloxidation.

If the urinary degree of acidity be less than 30, the acids formed are not being excreted, and are tending to accumulate in the system. If the urine contains acetone, acid formation is proceeding at an intense rate, and this is still more the case if diacetic acid be present; while the presence of B-oxybutyric acid indicates deep-seated, intensely poisonous metabolic changes. A decrease in the acidity of urine in a traumatic (whether surgical or not) indicates the imminent possiblity of some nervous explosion, which may vary from an intense neuralgia to coma, and to an agitated confusional insanity.

The therapeutic indications are to decrease acidosis by the use of alkalies, pre-eminent among which is sodium bicarbonate, and to increase elimination. As the strain is chiefly on the kidneys, elimination should be diverted from these organs to the intestinal canal by the use of hydragogues, such as elaterium, chionanthin, etc., followed in a day or two with a saline laxative which should be continued for some time.

The cardiac strain, resulting from exaggerated arterial tension due to the acid states, should be guarded against by the use of respiratory stimulants like strychnine and aspidospermine, since these drugs better than any others will give tone to the heart and increase oxidation, the diminution in which is one great factor in the acid conditions, whether resultant on traumatism, or in other causes.

The question of sleep, or rather, of rest, will require attention. Were it not for their effect on the intestinal secretions, opium and its alkaloids would be ideally indicated, since they are good cardiac tonics as well as narcotics. The influence which opium and its alkaloids have on the secretions, however, contra-indicates their use (with the exception of apocodeine muriate, which alone has a laxative action). Heroin has less inhibitory influence than morphine, but its exhibition hypodermically is apt to be attended by nausea.

Dr. Seabrook's paper, "Diabetes Mellitus and its Curability" interested me as does nearly every contribution on this subject.

When reading Dr. Seabrook's article, I was reminded of the interrelation of diabetes and other constitutional states.

Conditions such as express themselves in glycosuria and allied suboxidations readily occur in the neuroses. Hysteria may be compli-

cated for instance with glycosuria of transitory or prolonged duration, which may eventuate in coma of an apparently diabetic type, but disappears with the disappearance of the most marked hysterical symptoms. The great neuroses, paretic dementia, locomotor ataxia and epilepsy, occasionally display temporary glycosuria. So do delirium tremens and the confusional insanities. Every one of the fibrile conditions may be glycosuric. Conditions in which respiration is involved are often accompanied by glycosuria. Pregnancy being a condition in which there is over-nutrition, faulty elimination, and resultant imperfect oxidation is often attended by glycosuria. Gout and insanity of the auto-toxic types frequently alternate with glycosuria.

Diabetic absorption of oxygen is much less than normal, and decreases till toward the end of the disease when it is hardly half the normal quantity. Carbon dioxide exhaled is proportionally reduced. The oxygen decrease, Sajous ascribes with much plausibility to suprarenal disorder. Increased suprarenal activity, as Croftan has shown, can so augment the ferment producing power of the pancreas as to greatly increase sugar elimination through the increase of the amylolytic ferment supplied by the pancreas which converts the liver glycogen into dextrose.

Herein lies the explanation of neuropathic glycosuria and of diabetic neuropathics. In the first, the cause is primarily in the cerebro spinal system. In the second, the system composed of the liver, pancreas, spleen and adrenals is first affected, and the resulting toxic products because of disordered oxidation, cause the nervous symptoms.

In treating diabetes and glycosuric and acidosic states we must remember that four things are necessary, no matter what other treatment is employed.

1. Increase oxidation. This can be done by the administration of strychnine and aspidospermine, and by hydrotherapy. Cold sponging down the spine and on the inner and outer aspects of the thighs is apt to be attended by a rapid tonic reaction, which increases the circulation from the interior to the exterior, thereby tending to increase oxidation.

2. Favor elimination by all channels. The kidneys may be in good condition themselves, yet because the intestines are acting imperfectly with fecal resorption, the kidneys are overworked, as is shown by the presence of indican and urea in the urine. Secondary to this occurs renal insufficiency with resultant acidosis from retention of imperfectly oxidized sugar products. Free purgation by means of hydragogues and hepatic stimulants, such as elaterium, chionanthin, baptisin, apocynin, leptandrin, podophyllin, etc., with a saline laxative is urgently indicated.

3. Overcome acidosis by the free administration of a saturated solution of sodium bicarbonate.

4. Counteract tendency to autointoxication, particularly intestinal toxemia. This can best be accomplished by diuretics, diaphoretics and especially by laxatives, such as I have already mentioned, together with intestinal antiseptics, the best of which are sulphocarbolates with bile salts.

The common erroneous assumption that morbid states occurring during a diathetic state are due to it, is peculiarly accepted as to diabetes. While there is more truth in the assumption as regards diabetes, still treatment of symptoms and local conditions will often do as much to relieve diabetes as treatment of diabetes does to relieve them.

GEORGE F. BUTLER.

103 State St., Chicago, Ill.

The Report of the Parsons Hospital for Epileptics for the biennium ending June 30, 1906, gives the reader considerable food for thought. Superintendent Perry gives thirteen pages of report, in which he tries to show the absolute necessity of greater appropriations and more business like methods. He says that the board of control system is an improvement over its predecessor but that there still remains much to be done before the institution will be as well managed as would a private business of equal magnitude. It strikes us as peculiar that an institution wherein the treatment is largely by the use of agriculture, should be located in a place where the soil is notably thin and the surface drainage poor. We have heard stories about the sum of money which Parsons sent to the legislature to secure the location of the institution there. The report of the superintendent about the soil, and about the step-mother-like treatment afforded the institution by the Parsons water department and the natural gas company, leads us to believe the story true. Dr. Perry is handicapped by a lack of buildings and equipment generally. Evidently appropriations and plans have been made with small consideration of professional needs and wishes. However, we hope that the new board of control will do better by the institution.

Location—I have a good location which I will give free to purchaser of my drug store. The stock will invoice about $475. Ability to speak German will be of assistance. I want to leave by Feb. 1st, to take a post graduate course. DR. JAMES WELCH, Tampa, Kansas.

Society News.

The Council meets February 5, at Dr. Munn's office in Topeka.

The Cherokee County Medical Society held one of the best meetings in its history in Galena on Tuesday 12-11-06. There was a large attendance from all over the county. Two applications for membership were favorably reported, which, if elected, will give us a total numbership of about 31 out of about 55 registered physicians in the county. A steady campaign is being conducted among the non-members and before the end of the year we expect to have all the eligibles enrolled. Two excellent papers were read and freely discussed by the society. Dr. Fred D. Northrup on Pneumonia and Dr. Chas. S. Huffman on Quarantine and Fumigation. The program committee reported a program for 1907 which was adopted by the society.

The officers for 1907 are: President, J. P. Scoles; Vice President. R. C. Wear; Secretary and Treasurer, R. C. Lowdermilk.

The question of fees for insurance examination was discussed at length, and resulted in the adoption of the following resolution offered by Dr. Chas. S. Huffman, Secretary of the State society.:

RESOLVED: That it is the sense of the Cherokee County Medical Society that five dollars is a fair minimum fee for life insurance examinations and we ask that this matter be taken up at the meeting of the state society in that they adopt a resolution pledging the members not to make examinations for the old line companies for less than five dollars.

The next meeting will be held in Baxter Springs, Jan. 8, 1907.

R. C. LOWDERMILK,
Secretary

Clay County—Program for January 8, 1907:

"Tonsilitis .....Dr. R. C. Harner, Green
"Fractures and Their Management," .....Dr. J. P. Kaster, Topeka
"Nervous Diseases," ..... Dr. Lyman L. Uhls, Osawatomie

Dr. Porter is the new president; Dr. Olsen the new secretary.

Dickinson County—We had a representative crowd at our annual meeting, and the same was an enjoyable affair. The following officers were elected for the year:

President, Royal McShea, Chapman.
Vice President, E. E. Hazlett, Abilene.
Treasurer, J. D. Riddell, Enterprise.

Secretary, Chas. B. Buck, Abilene.
Censor, three years, Geo. E. White, Solomon.
Delegate to state society, J. D. Riddell.
Alternate to state society, P. B. Witmer.

Our society has twenty-two members; we lost two by transfer and gained others in their places. While our work has brought the profession into a more friendly relationship, much more along that line could be done. In the main our men are working along ethical lines. Only one man in the county is doing "contract lodge" practice. The question of a local hospital is under serious consideration and will be probably financed soon. Steps will be taken to call the attention of our druggists to their ethical relations, and especially to quack nostrums so publically advertised.

CHAS. B. BUCK,
Secretary.

The Elk County Medical society met at Howard, Dec. 18, 1906. On account of a great deal of sickness and a cold day, there were very few members present. The meeting was called to order by the president, Dr. W. H. Smithers, in the chair. Minutes of the last meeting read and approved. The papers which had been promised for the meeting were not produced. The secretary read a paper on the registration law, which was well received. Dr. C. A. Trowbridge of Howard, made some felicitous remarks on his observations while in Europe attending the hospitals. The officers of the society were re-elected to serve another year. Our next meeting will be in January.

Jefferson County Medical society held its annual meeting in the office of Dr. G. W. England, Valley Falls, Dec. 27, 1906. The meeting was called to order by President Dr. E. C. Rankin, McLouth. An interesting program was given, consisting of talks on the following subjects:

"The Treatment of Gonorrhoea,"
"The Old vs. The Young Physician."
"Specific Medication."
"Consultation."
"Value of Hospital Facilities in Country Practice."

Annual election of officers resulted as follows:
President, Dr. Stephen E. Smith, Grantville.
Vice President, Dr. G. W. England, Valley Falls.
Secretary, Dr. L. V. Sams, Rock Creek.
Treasurer, Dr. W. L. Borst, McLouth.

Board of Censors, Dr. E. C. Rankin, McLouth; Dr. W. L. Borst, McLouth; Dr. Ira Puderbaugh, Ozawkie.

Delegate, Dr. S. E. Smith, Grantville.

The members were treated to a banquet and smoker, after which the meeting adjourned to meet in Oskaloosa about March 1. The new year bids fair to be one of the best for the interests of the Jefferson County Medical society. But three years old, it has enrolled among its members the full quota of eligible physicians in Jefferson county with the exception of three.

L. V. SAMS,
Secretary.

Leavenworth County—The annual meeting for election of officers was held Dec. 17, 1906. The result follows:

President, Stewart McKee.
Vice president, R. L. Boling.
Secretary, J. W. Risdon.
Treasurer, C. E. Brown.
Board of Censors, C. C. Goddard, A. J. Smith, P. W. Darrah.

J. W. RISDON.
Secretary

Montgomery County—We have added to our number Dr. E. W. Curd, Capon, Ind. Ter.; Dr. Milton T. Evans, Sedan, Kan.; Dr. G. W. Goss, Sedan, Kan.; Dr. W. T. Courtwright, Sedan, Kan. We have divided into four sections, to meet each at Cherryvale, Independence, Coffeyville, and Caney monthly. We will have four general meetings a year of the entire society. One at each town named. The 1907 officers are:

President, Dr. T. A. Stevens, Caney.
Vice President, Dr. H. M. Casebeer, Independance.
Secretary, Dr. J. R. Scott, Independence.
Treasurer, Dr. B. F. Fortner, Coffeyville.
Dr. W. H. Hall re-elected censor.
Delegate, Dr. I. B. Chadwick, Tyro.

The program of our last meeting follows:

Annual Address ..... Dr. T. A. Stevens
Report of a case ..... Dr. J. H. Dalby
A paper ..... Dr. I. B. Chadwick
Peritonitis ..... Dr. G. J. Bigelow
A paper ..... Dr. Mary J. Martin

DR. J. R. SCOTT,
Secretary

Shawnee County Medical society held its regular meeting January 7, 1907. The application of Dr. Kiene of Christ's Hospital was presented and referred to the censors to be reported upon at the February meeting. The censors reported favorably on the applications of Dr. R. A. Taylor

and Dr. A. B. Jeffrey, presented at the December meeting and both doctors were unanimously elected to membership.

The application of Dr. C. F. Menninger, which was presented at the December meeting was also favorably reported by the censors and the society elected him to membership on the condition that he resign from his homeopathic societies. Dr. W. E. McVey and Dr. O. P. Davis were appointed a committee to circulate a petition to congress against the osteopathic bill. The insurance resolutions recommended by the Kentucky State medical society were adopted.

CORBAN E. JUDD,
Secretary.

Washington County—The second annual meeting and banquet of the Washington County Medical society was held in this city Wednesday afternoon, and evening, December 19, 1906. The afternoon program consisted of a paper, "Some Thoughts Relative to Otitis Media" by Dr. H. L. Alkire, Topeka. The doctor presented his thoughts in a most skillful manner and the way he explained and demonstrated the anatomy of the middle ear ,etc., by drawings(chalk) proved his ability as a teacher and was greatly appreciated by all present. The paper was discussed by Drs. Stewart, Algie, Rudolph, Schwartz, Gardner, Porter and Smith.

Dr. John Outland of Topeka presented his paper, "Diseases of the Cervix," in a very able way and it brought forth a general discussion by Drs. Porter, Stemen, Algie, Rudolph and Armstrong.

Dr. C. M. Stemen of Kansas City, Kansas, had a very interesting paper, "Extra Uterine Pregnancy" and reported four cases. The paper was enjoyed by all and discussed by Drs. Outland, Schwartz, Stewart, Porter.

Dr. John Punton, Kansas City, Mo., presented a very excellent paper "Nervousness, its Significance and Treatment," which was well received but owing to the lateness of the hour, the discussion was limited. The paper was certainly rich in thought and his advocacy of state aid and hospitals for the treatment of the curable cases of insanity should be taken up by the medical profession of the state. After the election of officers and the general routine of business, we adjourned until 8:30 o'clock for the banquet at which about twenty doctors and their wives were present. Dr. H. D. Smith performed the duties of toastmaster in a very pleasing manner.

Toast, "Our Profession, " Dr. Robt. Algie.

Toast, "Medical Organization," Dr. H. L. Alkire.

Toast, "The Doctor," Sam'l Clarke, (Editor)

Toast, "Doctors' Dreams and Hopes," Dr. J. C. Rudolph.

Officers for 1907 are:

Pres., Dr. E. Armstrong, Greenleaf.

V. Pres., Dr. M. H. Horn, Morrowville.

Secy., Dr. H. D. Smith, Washington.

Treas., Dr. Wm. Jacobs, Washington.

Members present: Drs. Gardner, Armstrong, Horn, Runkle, Algie, Shearburn, Nelson, Rudolph, Tooley, Smith, Earnest, Jacobs, Maintz, and Snyder.

Visitors: Drs. Porter, Stewart and Schwartz of Clay Center, and Carter of Washington. Editors: Clarke and Ingalls.

Following is the corrected list of the members of the Washington County Medical society for 1906.

E. Armstrong, Greenleaf.
M. N. Gardner, Greenleaf.
Z. H. Snyder, Greenleaf.
Robt. Algie, Linn.
R. W. Maintz, Linn.
J. H. Hoover, Haddam.
E. W. Shearburn, Haddam.
J. C. Rudolph, Hanover.
J. O. Chambers, Hanover.
M. H. Horn, Morrowville.
H. D. Smith, Washington.
Wm. Jacobs, Washington.
W. M. Earnest, Washington.
R. A. Williams, has moved away, at present in Kansas City.
W. S. Runkle, Washington.
C. R. Nelson, Washington.
G. E. Tooley, Washington.
J. R. Mathews, Hollenberg, moved to Oneida and transferred to Nemaha county.

GEO. E. TOOLEY,
Secretary.

The Crawford County Medical Society met Monday evening, January 14, at the office of Drs. Bogle and Stelle, with the following members present: Drs. Graves, Bogle, Stelle, Wm. Williams, Sloan, Caffey, Cole, Harper. Following is the result of the election of officers for the ensuing year:

President, H. B. Caffey; vice president, Geo. E. Cole; secretary and treasurer, F. A. Harper.

Dr. J. J. Cavanaugh, of Walnut was elected to serve on the board of censors, succeeding Dr. H. H. Bogle, the retiring member. Board of

Censors: J. J. Cavanaugh, 3 years; E. O. Sloan, 2 years; Wm. Williams 1 year. Committee on public health and legislation, H. L. Stelle, F. L. Keeler and L. P. Adamson. Applications for membership received and acted upon favorably by the society: Dr. L. A. Newton, Chicopee, and Dr. Chas. Chapin, Frontenac.

Following is the report of committee appointed at a previous meeting to draft a set of resolutions condemning the unethical methods of advertising or reporting cases in the public press:

1. RESOLVED: That the publication in the lay press of the description of operations, attendance upon cases of sickness, and allied medical matters, in connection with the names of the members of this society be condemned.

2. RESOLVED: That the secretary be instructed to place in a scrap book, for inspection by the members all articles appearing in the press with the names of attending physician and that any member whose name appears have the privilege of attaching an explanation thereto.

3. RESOLVED: That a copy of these resolutions be published in the Kansas State Medical Journal.

(Signed) E. O. SLOAN.
R. H. MCDONNELL
H. H. BOGLE.

Dr. Geo. E. Cole brought to the attention of the society the importance of reporting all deaths and births to the county health officer; that many times questions of vital importance arose, which only the records of the county could clear up; such records can be correctly kept only as the individual physician sends in a report of his individual cases. The law provides that these reports be made or a penalty imposed. Proper blanks for this purpose are furnished by the county health officers. It is to be hoped that physicians will pay more attention to this matter this is the only way whereby the vital statistics of the country can be correctly obtained.

The use of the study of the Christian Church has been tendered the society as a permanent place of meeting; it is conveniently located, heated and lighted, and has telephone connection.

Adjourned to meet the first Monday in February.

FRANCES A. HARPER,
Secretary.

Western Kansas Medical Society convened at Colby, Kansas, January 9, 1907. Meeting was called to order by the president, V. C. Eddy, with the following members present: Drs. Eddy, Stoner, Blake, Marsh, Forbes, Carmichael, Beckner, Smith, Gulick, Lowis, Stroup, and Winslow. Visitors present: Dr. J. G. Sheldon, Kansas City; Dr. W. H. Schultz, Kansas City; and Dr. Townsend, Brewster. Usual routine of business was taken up and disposed of and the following officers for the ensuing year were elected by a unanimous ballot:

Dr. V. C. Eddy, Colby, president.
Dr. C. D. Blake, Ellis, vice president.
Dr. F. A. Carmichael, Goodland, secretary.
Dr. C. M. Miller, Oakley, treasurer.

The most important feature of the business section was its action in relation to the present existing fee schedule for old line life insurances, and it was unanimously voted that on and after February 15, 1907, no examinations would be made by members of this society for less than the minimum fee of $5, and the following resolution adopted:

RESOLVED: That the resolutions adopted by the Kentucky State Medical society be and are herewith adopted by this society and that printed copies of the same with the names of all the members attached be furnished members that they may forward same to the several companies who are at present attempting to maintain the reduced fee schedule and that all physicians in the territory embraced in this society who are not at present affiliated therewith be furnished a copy of these resolutions and their cooperation in securing a just and equitable schedule solicited.

After the conclusion of the business meeting before adjournment an interesting program was rendered. Dr. Schutz of Kansas City presented a paper entitled "Some every day experiences in ophthalmology and otology," illustrated by superb drawings which was highly interesting and practical. Dr. J. G. Sheldon addressed the meeting on the subject of "Aesepsis in emergency surgery," which was brief, but very forceful. Papers were presented by Drs. Stoner, Beckner and Stroup on the subject of Diphtheria and diseases of the tonsils, and the Asepsis in Obstetrics, which were carefully prepared and covered the ground fully. The next meeting of this society will be held at Oakley the second Wednesday in April.

Drs. Forbes and Beckner, Selden, presented a case of chronic appendicitis, one of cordiac spasm and one of complete procidentia uteri. Dr. Lowis of Colby, presented a case of hernia cerebri, which was a beautiful illustration of this rare condition. F. A. CARMICHAEL, *Secreeary.*

The Annual Meeting of the Northeast Medical Society will be held in Holton, Thursday, February 14, 1907.

Program

The Interdependence of the general practitioner and the specialist .....Dr. R. V. Adams, Holton
The county hospital .....Dr. Benj. Skinner, Wetmore
Pure food .....Prof. E. H. S. Bailey, Lawrence
Proposed state legislation in accordance with the pure food laws .....:Dr. G. E. Locke, Holton
Tonsilitis .....Dr. R. C. Townsend, Centralia

Rheumatism.....Dr. Noah Hayes, Seneca
Paper .....Dr. H. L. Chambers, Lecompton
Paper, ...Dr. J. A. Best, Centralia
Electro-therapeutics.....Dr. U. G. Iles, Seneca
Hernia, ...Dr. S. Murdock, Jr., Sabetha
Pott's disease, its etiology, pathology and diagnosis.....
.....Dr. J. R. Mains, Whiting
Notes on exophthalmic goiter..... Dr. E. W. Reed, Holton

The Wilson County Medical Society met at Fredonia December 11. By special invitation Dr. L. D. Johnson, of Chanute, read a paper on "Some Phases of Abdominal Surgery." It was a masterly paper, and thoroughly enjoyed by those present. There still being time, Dr. Edwards of Chanute, read a paper on Tonsilitis, which was well received. The following officers were elected for the year 1907: Preston, Buffalo, president; Duncan, Fredonia, secretary and treasurer. Several applications were taken for membership. Next meeting will be at Fredonia, second Tuesday in February. J. L. HAYS, *Secretary*

Cowley County Medical Society met in regular session December 13, 1906, at Arkansas City. The following officers were elected:

President, Dr. J. H. Guinn, Arkansas City, Kan.
Vice President, Dr. Willis H. Hall, Winfield, Kan.
Treasurer, Dr. O. B. Wyant, Winfield, Kan.
Secretary, Dr. H. L. Snyder, Winfield, Kan.

The society has made a good gain for the year; nineteen new members were added.

The following resolutions were adopted:

WHEREAS, The members of the Cowley County Medical Society view with horror the many cases seen by them showing evidence of criminal operation; and whereas many people with the highest moral principles and pretending Christianity claim to think it perfectly right and free from danger to co-operate in the criminal work daily done; and whereas the act is not only a crime in the eyes of God and man, but is statutory crime punishable by penitentiary service and revoking of license of the operator and penitentiary service for those operated upon or those co-operating, and whereas the knowledge of the penalty of the great crime is viewed so lightly by the young as well as many in marital life; and whereas, the results of such criminal practice, is undermining the health of thousands, sending many to an untimely grave, is lowering the standing of the medical profession and degrading the morals of the younger generation.

Wherefore, be it resolved by the Cowley County Medical Society, in council assembled, that individually and collectively, we will do everything in our power to stop this deplorable practice, and further be it resolved, that this society offer a reward of $100.00 for the arrest and conviction of any person or persons guilty of said crime and

Further be it resolved, that the secretary of the society furnish a copy of these resolutions to the Journal of the Kansas Medical Society for publication.

H. L. SNYDER, *Secy.*

Book Reviews.

Surgery: Its Principles and Practice. In five volumes, by 66 eminent surgeons. Edited by W. W. KEEN, M. D., L. L. D., Hon. F. R. C. S., Eng. and Edin., Professor of the Principles of Surgery and of Clinical Surgery, Jefferson Medical College, Philadelphia. Cloth, $7.00 per volume. W. B. SAUNDERS Co.

The first volume of this work, which is to consist of five volumes is just out. The other volumes are to follow at intervals of about three months. The first volume is octavo of 983 pages, with 261 text illustrations and 17 colored plates, and the list of names among the contributors comprise those most eminent in their lines today.

J. G. Mumford, Instructor of Surgery at Harvard, begins the work with a narrative of surgery: A Historical Sketch, which is interesting even from a lay point of view, but which from a medical view-point gives us a good sketch of prominent physicians from the time of Hippocrates to Lister.

George W. Crile, Professor of Clinical Surgery at Western Reserve, contributes the chapters on Surgical Physiology and wounds and contusions. Those who know of Crile's work on blood pressure, will be glad to learn that the gist of his experimental work, as it relates to surgical shock, is set down here. His is a work that is at the same time scientific and practical. John C. Da Costa, Jr., Associate in Clinical Medicine, Jefferson Medical College; hematologist to the German hospital, Philadelphia, contributes a chapter on Examination of the Blood, and treats his subject in relation to surgery. Ludwig Hektoen, Professor of Pathology in the University of Chicago, and Director of the Memorial Institute for Infectious Diseases, discusses Infection and Immunity. The cardinal conditions of infection are set down concisely and the question of immunity is presented in the plainest and most readily intelligible way that the writer has seen. J. G. Adami, Professor of Pathology at McGill, writes on Inflammation—certainly, on account of the "many diverse pictures of inflammation" a difficult subject. His definition is as follows: "Inflammation is the condition or series of conditions into which tissues enter as a reaction to irritat on."

Leonard Freeman, Professor of Surgery, Denver and Gross Medical College of Medicine, follows with chapter on Suppuration, Abscess and Fistula, Ulceration and Ulcers, and Mortification and Gangrene. F. C. Wood, Professor of Clinical Pathology at the College of Physicians and Surgeons of Columbia University, contributes a very instructive chapter

on the Process of Repair. Not only are the general methods of repair considered, but also repair in the different organs and tissues. By far the largest contributor to this volume (from the point of view of the number of subjects), is C. H. Frazier, Professor of Clinical Surgery at the University of Pennsylvania. One chapter each is devoted to Thrombosis and Embolism, Erysipelas, Tetanus, diseases caused by Special Infections, Diseases Derived Directly from Animals, Insects and Reptiles and Scurvy. While some of the subjects are chiefly medical, they also have a surgical side and this is the side chiefly discussed, although the medical is by no means omitted. E. A. Smith, Adjunct Professor of Clinical Surgery of the University of Buffalo, devotes a chapter to the Traumatic Fevers. "The traumatic fevers are febrile conditions accompanied by definite symptom complexes which follow traumatisms anywhere to the body, whether infection of the contused or wounded area does or does not occur." Only traumatic aseptic or primary wound fever, septicaemia and pyaemia are considered as traumatic fevers. Rickets is discussed by E. H. Nichols, Assistant Professor of Surgical Pathology, Harvard Medical School. J. Chalmers Da Costa, Professor of the Principles of Surgery and Clinical Surgery at Jefferson Medical College, gives us the chapter on Surgical Tuberculosis which deals broadly with the subject from the historical to the discussion of tuberculosis of the different organs. Edward Martin, Professor of Clinical Surgery, University of Pennsylvania, writes the chapters on Chancroid and Syphilis. Chancroid is treated principally from a medical standpoint while Syphilis is as thoroughly treated as in most texts on skin diseases. J. Bland-Sutton, F. R. C. S., Eng., is the only foreign contributor to this volume. He devotes 144 pages to the discussion of tumors, which are divided into six groups—Tumor diseases of the connective tissues, tumor diseases of the teeth, epithelial tumors, tumors arising from the chorionic villi, teratoma and dermoids and cysts.

Each of these chapters is written by men especially qualified to discuss the subject and while it may be argued that such a method produces a disconnected book, one cannot say that it detracts any from the value. And the subjects, while briefly discussed, are complete. The necessity for conciseness is perhaps one of the advantages in such a volume as it does away with too much theoretical discussion and prolixity.

Another feature of the work is a complete bibliography following each subject. In the words of the editor, it is "Our aim to record the very latest, well-established, knowledge so that the work should be up-to-date, yet with few, if any, passing surgical novelties," and the reviewer believes it has done this and more.—S. C. E.

Grayson's Larynology. The diseases of the Nose, Throat and Ear. By CHARLES P. GRAYSON, M. D., Clinical Professor of Laryngology, Medical Department, University of Pennsylvania. New (2d) edition, revised and enlarged. Octavo, about 550 pages, with 152 engravings and 15 plates in black and colors. Cloth, $4.00, net. Lea Brothers &Co., Philadelphia and New York, 1906.

A medical student saw this volume lying on your reviewer's desk and proceeded to dip into it. He found it so interesting that he took the book home and returned it only with reluctance. "It reads so easily and is so instructive that I have learned a lot from it. It is just like Osler."

That student's opinion is quite our own. The author is perfectly sane and shows none of the radical tendencies and fads so often found in rhinolaryngologists. Lack of space prevents a detailed study of the book in this issue. This we hope to present that later,—but we hope that our readers will not hesitate to secure the book for themselves.

G. H. H.

The Practice of Gynecology, by W. EASTERLY, ASHTON. M.D., L. L. D., Professor of Gynecology in the Medico-Chirurgical College of Philadelphia. Third edition Thoroughly revised. Octavo, pp. 1096; 1057 original line drawings. W. B. Saunders & Co., 1906; cloth, $6.50; half morocco, $7.50.

It is worthy of note that this is the third edition of this work within a year; nothing could speak more forcibly as to the value of the work to students and practitioners.

A notable feature of the text is the number of illustrations all taken from original operations or apparatus. All told there are 1057 of them including illustrations of the instruments necessary in the various operations which is of undoubted aid to the young operator, or one who has not learned from hospital training just what instruments he is going to need. Another feature is the method in which the author approaches a subject. Instead of a general chapter on anatomy and diagnosis, by means of physical examination, he takes up the anatomy and the method of examination of each organ or part by itself, and then takes up its diseases and the treatment. And in the treatment—instead of confusing one with everyone's treatment he gives that one which he has found best, stating in addition those changes necessary to peculiar conditions and variations in the disease under discussion. But while the book represents the personality of the author it is not narrow as is seen by the advocacy of Dudley's method of operating for cystocele, Moynihan's method for intestinal anastomosis and others.

The details of treatment as well as of diagnosis are fully set forth and for the man who does not know it all, and wishes to learn, and for the occasional operator, these very details are the most valuable part

of the book. The author writes on the basis that the reader wishes the details and all of them. This idea carries itself into the consideration of diseases—even the urethral caruncle and adhesions of the clitoria are fully described and treated.

The chapter on the blood in its relation to surgery is a valuable one for the surgeon who has an assistant or an internist to make the necessary examinations. Even then there are few recent graduates who are qualified to make such examinations which perhaps accounts for the author's statement that "so far as surgical conditions are concerned, the blood findings are not pathognomonic in character and are too contradictory and conflicting to be relied upon as the sole means of making a positive diagnosis."

In the chapter on microscopical and bacteriological examinations, he gives careful instructions as to the manner of preserving and sending material to the pathologist so that it will arrive in good condition. The method of collecting correct findings is especially commended to the man who is tempted to swab out the uterus with a wad of cotton and send it to the pathologist asking an opinion relative to carcinoma.—S.C.E.

Diet in Health and Disease, by FRIEDENWALD & RUHRAH of the College of Physicians and Surgeons, Baltimore. Second edition, 1906. W. B. SAUNDERS Co. Cloth, pp. 728, price $4.00.

The reviewer has used the first edition of this work for over a year and when in doubt about a certain article of diet or the proper feeding in a particular disease, has never failed to find at least a part of what he wished in this text.

The principles of diet are brought out so cleverly and the composition of various foods set down so concisely that one may readily select an extraordinary diet for a particular case. Not even the diet for athletes is neglected and the comparison between that of English and American athletes is interesting. The author in regard to alcohol states that it cannot be looked upon as a food tending to repair tissue, but merely as a fuel that on oxidyzing, forms animal heat. Attention is also given to the feeding of infants and surgical cases, and the short account of the diet at some water cures which is given to all patients alike regardless of the disease is rather in the nature of censure

The addition of the rapid reference diet lists in the new editions is a decided improvement over the first edition, in that it increases the convenience of the book for the busy physician.—S. C. E.

Golden Rules of Pediatrics, by JOHN ZAHORSKY, A. M., M. D., Clinical Professor of Pediatrics, Washington University, St. Louis, Mo. C. V. MOSBY Medical Book Publishing Co., St. Louis, Mo. Cloth, price $3.00

This work will fill a vacant spot in the ordinary medical library, consisting as it does of terse statements and brief precepts. It cannot go into detail, but its use as a reference book will undoubtedly

put many of us on the right track in the diagnosis of the little patients presenting so few symptoms. Many new and valuable hints in approaching children, how to examine them without frightening them, and how to apply remedies with the least inconvenience are stated.

There are few of us who will not be enlightened by some such statement (and the book is full of them) as "Hutchinson's teeth indicating syphilis occur in the permanent teeth and not in the milk teeth."

The double index adds to the value of the book by making the contents more readily accessible. A single symptom can be quickly traced to the several diseases in which it occurs and by reference to the therapeutic index one quickly finds one or more methods of treatment for a particular ailment.—S. C. E.

Obstetrics for Nurses, by JOSEPH B. DELEE, M. D., Professor of Obstetrics in Northwestern University Medical School. 510 pages, fully illustrated; cloth, $2.50 net. W. B. SAUNDERS CO.

From a physician's standpoint, this text seems almost ideal for the obstetrical nurse's guidance. The illustrations are numerous and good and comprise not only the arrangement of patient and bedding, but also convenient arrangement of tables and instruments are named and most of them illustrated for the principal operations which is useful to the physician as well as the nurse.

The diet for infants is given attention and a dietary for the mother which include not only the foods but how to prepare them.

The glossary of new words and terms completes a work which should be in the hands of every obstetrical nurse.—S. C. E.

Hirst's Text-book of Obstetrics, by BARTON COOKE HIRST, M. D., Professor of Obstetrics in the University of Pennsylvania. 899 pages, with 746 illustrations, 39 of them in colors. Cloth, $5.00; sheep or half-morocco, $6.00. W. B. SAUNDERS CO., Philadelphia.

"Hirst's" has been a standard for students and a guide for physicians for so long that mention need be made only of the most striking features of the fifth edition which is just out.

The first thing that attracts one's attention is the large number and the excellence of the illustrations. Many of these illustrations are from the author's cases and appear for the first time.

While disputed theoretical points are discussed enough to present different views and make them intelligible the book is not lumbered with such. In fact, the book is characterized by clear,concise statements and careful detail which combined with the illustrations, probably account for the popularity of the book.

In this edition more space has been devoted to the pathology of the puerperium and the diseases of the genital organs incident to childbirth. The one chapter on puerperal sepsis is worth the price of the book. This is a new chapter, and while one might not agree that a hysterectomy is advisable under septic conditions the reason for such an operation, under certain circumstances, advanced by the author, cause one to think that the hysterectomy with drainage is less dangerous than the unchecked septicemia especially when he cites cases where uterine douches produced harmful results.—S. C. E.

Prevalent Diseases of the Eye, by SAMUEL THEOBALD, M. D., Clinical Professor of Opthalmology and Otology, Johns Hopkins University. 550 pages, 200 illustrations, 10 in colors, cloth, $4.50 net. W. B. SAUNDERS CO.

This book is written for the general practitioner, assuming that he should be able to diagnose and treat more ocular diseases than he does without expecting him to become a specialist or take special training, It is rather novel in that the author, himself a specialist, should suggest that the physician should care for more of his eye cases, instead of sending them to the specialist.

The use of instruments difficult of manipulation, such as the ophthalmoscope, the consideration of such rare affections as those of the ciliary body and those diseases especially difficult of diagnosis or treatment, are omitted. They are more properly left for the consideration of the specialist. But those diseases of the anterior orbital parts (hordeoleum, conjunctivitis, iritis, blepharitis marginalis) are considered in detail and in such a way,both as to diagnosis and treatment,as to be most useful to the man in general practice.—S. C. E.

Saunders' Pocket Medical Formulary. Eighth edition, flexible morocco, wallet and flap. W. B. SAUNDERS CO., $1.75 net.

A very convenient pocket prescription book compiled by Wm. Powell, M. D., in accordance with the new pharmacopeia. Besides 1800 formulas, new and old, it has blank pages for the physician to set down individual prescriptions. There is a condensed table of poisons and their antidotes, a concise table of incompatibles and a posological table. Altogether a little book full of useful information especially for the younger generation of physicians whose training in prescription writing has been neglected.—S. C. E.

American Illustrated Dictionary. BY NEWMAN DORLAND, M. D. Red flexible leather binding, 836 pages. W. B. SAUNDERS CO. $4.50 net; with thumb index $5.

The book is printed on tough thin paper in small types so that while it is practically an unabridged dictionary it is convenient in size. The sub topics are readily found in a paragraph on account of the use of leaded type. The illustrations are excellent and there are 119 in colors. The type is small, as necessarily in a small volume, but plain. Obsolete terms and words are noticeable by their absence, while there are present all the new terms relative to immunity, which the general practitioner will doubtless find useful in his reading.—S. C. E.

Wanted—Partner. Town of 400. Must be a graduate, single, of good habits. Income moderate. Address Dr. H. M. Ochiltree, Haddam, Kansas.

Nothnagel—8 Vols.—(1905)—absolutely new, for sale for $25. Cost $40. Write No. 42, care of THE JOURNAL, Rosedale, Kansas.

News and Notes.

Sixth International Determatological Congress will be held Sept. 9 to 14, 1907, at the Academy of Medicine, 17 West Forty-third street, New York City. Membership costs $5, but the meetings are open to the public. Abstracts of papers and registrations should be sent before May 1, to Dr. Jno A. Fordyce, secretary general,80 West Fortieth street, New York City. The first congress of this kind met in Paris in 1889 and since that time, at intervals of about three years it has been held n Vienna, London, Paris and Berlin. At the Berlin meeting in 1904 New York York was selected as the meeting place for 1907 and Dr. James C. White of Boston was elected president of the congress, the following organization committee having been appointed by him:

Dr. Chas. W. Allen*....New York	Dr. W. S. Gottheil.....New York
Dr. John T. Bowen,.....Boston	Dr. Milton B. Hartzel..Philadelphia
Dr. Andrew P. Biddle.....Detroit	Dr. James Nevins Hyde...Chicago
Dr. Edward B. Bronson..New York	Dr. George T. Jackson..New York
Dr. L. Duncan Bulkley..New York	Dr. Sigmund Lustgarten.NewYork
Dr. R. R. Campbell.....Chicago	Dr.D.W.Montgomery San Francisco
Dr. Wm. T. Corlett.....Cleveland	Dr. Prince A. Morrow...New York
Dr. I. Dyer.....New Orleans	Dr. Wm. A. Pusey.....Chicago
Dr. George T. Elliott....New York	Dr. Francis J. Shepherd..Montreal
Dr. Martin F. Engman...,St. Louis	Dr. Grover W. Wendo.....Buffalo
Dr. John A. Fordyce....New York	Dr.Henry W.Stelwagon Philadelp'ia
Dr. George Henry Fox..New York	Dr. James W. Winfield..Brooklyn
Dr. Thomas G. Gilchrist.Baltimore	Dr. Joseph Ziesler.....Chicago

*Since deceased.

The themes offered for discussion are:

I. THE ETIOLOGICAL RELATIONSHIP OF ORGANISMS FOUND IN THE SKIN IN EXANTHEMATA.

To be presented by Prof. W. T. Councilman, Boston.

To be discussed by Prof. Gary M. Calkins, New York.

II. TROPICAL DISEASES OF THE SKIN.

To be presented by Dr. H. Radcliffe-Crocker, London, England; Prof. G. Riehl, Vienna, Austria; Dr. William Dubreuilh, Bordeaux, France; Dr. W. H. Brinkerhoff, Honolulu; Dr. J. H. Wright, Botson.

To be discussed by Dr. C. W. Stiles, Washington, D. C.; Dr. Baldomero Sommer, Buenos Ayres, S. A.

III. A. THE POSSIBILITY OF IMMUNIZATION AGAINST SYPHILIS.

To be presented by Prof. A. Neisser, Breslau, Germany; Prof. Ernest Finger, Vienna, Austria; Dr. L. E. Leredde, Paris, France.

To be discussed by Prof. T. de Amicis, Naples, Italy.

III. B. THE PRESENT STATUS OF OUR KNOWLEDGE OF THE PARASITOLOGY OF SYPHILIS.

To be presented by Erich Hoffman, Berlin, Germany.

To be discussed by Dr. A. Buschke, Berlin, Germany; Dr. K. Herxheimer, Frankfort, a. m., Germany.

Vital Statistics:

As secretary of the Elk county society I have received a pamphlet and a copy of resolutions passed by the American Medical Association for the purpose of calling attention to the interest of vital statistics of the several states of our union, asking the cooperation of medical societies and physicians to the importance of a move for uniform method in registration of births and deaths. Either the laws of some of the states are inadequate, ambiguous, or the incentive to furnish certificates by those whose duty it is, would seem to be among the reasons for the present deplorable conditions. The pamphlet referred to emanates from the office of vital statistics at Washington, and gives the laws of Pennsylvania on this subject with special reference to registration of births and deaths as passed by the Pennsylvania legislature in 1905. It seems from a casual reading the law is a good one, but encumbered with some features that might be improved. The law, of course, is under the state board of health. It provides for a state registrar, who shall be a physician at a salary of $2,500, with adequate assistants and the state is divided into districts each of which shall have a registrar , who shall receive a compensation of 25 cents for each certificate of birth or death recorded. From every family where a birth or death occurs a letter of notification shall be sent to the registrar stating the fact.

The physician in attendance must make the certificate of birth or death without cost. A failure to furnish the certificate shall be deemed a misdemeanor subject to a fine.

No class of persons has a greater interest in vital statistics than the physicians, and we are supposed to take enough interest in that subject to make all returns accurately and promptly. But experience proves the contrary, i. e., that there are many physicians who say the state has no right to take my time to write a certificate and spend my money in sending that certificate to the proper authorities. And while there is a law in this state and perhaps all the others, with a penalty for neglecting this duty, it is constantly no doubt being neglected. I believe the difficul-

ty could be obviated by paying the physicians a reasonable compensation, say, 25 cents for each certificate made by him where he has attended the case in person, or in a case where no legally authorized person was in attendance. The same law should obtain as in Pennsylvania with reference to notifying the proper authority of each birth and death, so that a tally would be kept by the county health officer. These views met the approval of our society, and the following resolutions were passed:

Whereas, the vital statistics with reference to registration of births and deaths have not been and are not now given as accurately and promptly as the present law contemplates, and **whereas** physicians are the most interested and the best adapted to give such statistics, and

Whereas, the law of compensation for labor applies to physicians as well as others. Therefore be it

Resolved, that it is the sense of the Elk County Medical society, that the Legislature of Kansas be asked to pass an amended law on vital statistics as applied to registration of births and deaths, similar to the laws on that subject as now exist in the state of Pennsylvania. except that instead of the state being divided into districts, that each physician in the state qualified under the laws to practice medicine shall act as local registrar and for such service as making certificates of births and deaths whether in his own practice, or where there was no physician in attendance lawfully competent to make certificates he shall receive for each certificate the sum of 25 cents. This fee should be paid from the county funds where the birth or death occurs.

Howard, Kansas. J. L. HAYS.

IN MEMORIAM.

DR. L. A. BUCK.

After the funeral of Dr. L. A. Buck of Peabody the Marion County Medical society, a large majority of whose members had been in attendance; convened for the purpose of conferring on this, the first death of a member since its organization. After a number of individual members had expressed their grief and feeling of personal loss by Dr. Buck's deplorable death, a committee was appointed to prepare appropriate resolutions for publication. This committee offers the following:

Whereas the Marion County Medical Society has been called together for the mournful purpose of expressing by the presence ot its members, and by such words as it may find, the sorrow which can never be adequately expressed in language, but which custom and a desire to offer tribute by utterance has established, we present the following resolutions on the lamentable death of its foremost member, Dr. L. A. Buck: That this society unanimously voices its sincere sorrow over the grave of its beloved brother and esteemed member, Dr. L. A. Buck;

That the society as a whole and each member as an individual consider Dr. Buck's future absence from our meetings an irreparable loss to the scientific and progressive aims of our society and a still greater void will be felt by each one of us who had become accustomed to his cheery welcome and genuine and warm hand-shake.

Resolved that not only has the medical profession and this society sustained a great loss in the passing away of Dr. Buck, but that his patients and patrons will long lament his absence from their bedsides of suffering where his cheering, encouraging ways and words carried hope and ease; and from his office where many went in with drooping, despondent heads to come out with cleared eyes and a brighter outlook on the future.

Resolved that to his stricken family we offer our deepest, heartfelt sympathy for a sorrow which words cannot lift but which we can humbly present with the feeling of assurance that they will meet their loved and lost one in a longer or shorter interval as the court of human time goes but a second of eternity in the happier hereafter.

Signed { G. P. MARNER, J. WERTHNER, R. C. SMITH.

Memorial—We were very much shocked Friday morning, December 13, 1906, when a telegram was received announcing the death of Doctor Buck. He had been to Hot Springs to attend a meeting of the Rock Island railroad surgeons, and was taken sick on the train homeward bound. He was removed to the Rock Island hospital at El Reno, Okla., where he was from Saturday, December 8, until death claimed him. Our memories of Doctor Buck are of his kind and happy character. We of this society who have been associated with him in his profession will miss him exceedingly and will always remember his "Happy, happy, always happy" to our greeting, How are you doctor? When called in council, or asked for advice it was always carefully given, and in no uncertain manner, as it was acquired by a studious and a long professional career, having practiced medicine for thirty years. We will miss him from our meetings, as he was always enthusiastic in the discussion of our papers, on any subject brought before the society We cannot help but extend our sympathy to his family and the community; the one has lost a husband and father, the other a worthy citizen. At a meeting of the Peabody Academy of Medicine it was resolved that the above mentioned memorial is in accord to our feelings and that a copy be sent to the family of the deceased, our local paper and the Kansas State Medical Journal.

O. J. FURST, J. M. S. CHESSHIR
E. H. JOHNSON H. M. MAYER Committee.

REPORT OF THE COUNCIL ON PHARMACY AND CHEMISTRY.

We reprint herewith from The Journal of the American Medical Association, for September 15, the first installment of the report of the Council on Pharmacy and Chemistry. Additional installments will appear from time to time. The importance of these reports is too evident to need comment. For the first time in the history of the organized profession, a scientific commission, whose ability and probity is above suspicion, has reported on preparations regarding which heretofore we have had only the report of those interested, financially and otherwise, in their exploitation.

ACETOZONE.

A mixture of equal parts of benzoylacetyl peroxide and an inert absorbent powder.

Actions and Uses.—Benzoylacetyl peroxide belongs to a class of compounds known as the organic peroxides in which an excess of oxygen has been combined in such a way that it is somewhat slowly given off in a nascent condition. On contact with water it hydrolyzes, forming benzo-peracid and aceto-peracid which exert marked oxidizing and germicidal action. In consequence of this change, these compounds are thought to be particularly adapted for internal administration. The germicidal and antiseptic properties of this substance have been attested by the experimental results of several observers. It has been used in ophthalmic, aural and nasal practice with asserted good effects as an antiseptic. It has also been applied internally, especially in typhoid fever, with a view to the disinfection of the intestinal canal, and appears to be an intestinal antiseptic. Dosage.—Acetozone is generally employed in aqueous solution prepared as follows: Add acetozone to warm water in the proportion of 1 Gm. to 1000 Cc. (15 grains to the quart). Shake vigorously for five minutes, and allow to stand for about two hours. Decant the liquor as required. This solution may be drunk ad libitum, two quarts or more being taken by an adult in twenty-four hours. Acetozone is also used in oily solution as an inhalant. Manufactured by Parke, Davis & Co., Detroit, Mich.

ACETOZONE INHALANT.

A solution of benzoylacetyl peroxide in liquid petrolatum. Formula: One hundred grammes contain: Benzoylacetyl peroxide, 1.0 Gm.; chloretone (chlorbutanol), 0.5 Gm.; Refined liquid petrolatum, 98.5 Gm.

Dosage.—It is to be inhaled in the form of a very fine spray, or nebula best produced by an atomizer especially designed for oily liquids. Prepared by Parke, Davis & Co., Detroit, Mich.

ACET-THEOCINSODIUM.

Acet-theocinsodium, $C_7H_7N_4O_2Na + CH_3COONa$, a double salt of sodium acetate and 1.3 dimethylxanthine-sodium (theophyllinsodium).

Actions and Uses.—It has the diuretic properties of theocin, reinforced by the diuretic action of sodium acetate, and, being more soluble, it has been claimed to be more readily absorbed and better tolerated than theophyline. It is recommended in cardiac affections, nephritis, dropsy, etc. Dosage.—0.22 to 0.35 Gm. (3 to 5 grains) best given after meals. Manufactured by Farbenfabriken vorm. Friedr. Bayer & Co., Elberfeld, Germany, Continental Color and Chemical Co., New York).

ADNEPHRIN EMOLLIENT.

Recommended as a local application where prolonged use is required. Prepared by F. Stearns & Co., Detroit, Mich.

ADNEPHRIN OIL SPRAY.

The preparation is applied as a spray to the mucous membranes in congestive and inflammatory affections, preferably after washing with Dobell's solution. Prepared by F. Stearns & Co., Detroit Mich.

ADNEPHRIN SOLUTION.

A sterile solution 1-1000 of the suprarenal active principle in physiologic salt solution containing one-half of one per cent of methaform (chlorbutanol).

Actions and Uses.—The actions and uses of this preparation are described under Suprarenal Alkaloid. Dosage.—The dose internally is from 0.2 to 2.0 Cc. (3 to 30 minims) in water. Adnephrin is also used in oily solution as a spray, see Adnephrin Oil Spray, and in the form of ointment, see Adnephrin Emollient. Prepared by F. Stearns & Co., Detroit, Mich.

ADRENALIN.

The active alkaloid of suprarenal gland, prepared by the method of Takamine, see Suprarenal Alkaloid.

Dosage.—Locally, 1-1000 to 1-15000 solution, as the chloride. Internally, 0.3 to 2 Cc. (5 to 30 mm.) of 1-1000 solution. Hypodermically, 1 to 15 drops of 1-1000 solution, diluted with sterile water. Manufactured by Parke, Davis & Co., Detroit, Mich.

ADRENALIN CHLORJDE SOLUTION.

Dosage.—See adrenalin. Prepared by Parke, Davis & Co., Detroit, Michigan.

ADRENALIN SUPPOSITORIES.

I part of the adrenalin to 1000 parts of oil of theobroma (cocao butter). Each suppository weighs about 1 Gm. (15 grains). Prepared by Parke, Davis & Co., Detroit, Mich.

AGURIN.

Agurin, $C_7H_7N_4O_2Na + NaC_2H_3O_2$, a double salt of sodium acetate and theobromine-sodium.

Actions and Uses.—It acts like theobromine, over which it has the advantage of great solubility and that it is well tolerated by the stomach. While inferior in diuretic power to theophyllin (which see), it is said to have greater power in sustaining the diuresis produced. Dosage.—0.5 to 1 Gm. (7 to 15 grains), preferably in wafers or capsules. If in solution, this should be freshly prepared (with peppermint water) and without sugar or mucilage. Manufactured by Farbenfabriken vorm. Friedr. Bayer & Co., Elberfeld, Germany (Continental Color and Chemical Co., New York).

AIROL.

Airol, $C_6H_2(OH)_3(COOBiI(OH)) = C_7H_6O_6IBi$, a combination of bismuth oxyiodide (subiodide) and gallic acid.

Actions and Uses.—As it liberates iodine in the nascent state in the presence of wound secretions it has been recommended as a desirable and efficient substitute for iodoform in the treatment of wounds, burns, skin diseases, gonorrhea, etc. Dosage.—It is used externally in the pure state or diluted with talc, or in the form of a 10 per cent suspension in equal parts of glycerin and water, or as a 10 to 20 per cent. ointment with 2 parts of petrolatum and 7 parts of wool fat. Manufactured by F. Hoffman-La-Roche & Cie., Basle, Switzerland (The Hoffman-LaRoche Chemical Works, New York).

ALPHA-EUCAINE HYDROCHLORIDE.

Alpha-eucaine hydrochloride is the hydrochloride of benzoyl-methyl-oxypiperidine-carbonic methyl ester.

Actions and Uses.—The action of alpha-eucaine is similar to that of cocaine, but it is regarded as three and three-fourths times less toxic than cocaine. In large doses it first stimulates and then paralyzes the central nervous system;it slows the heart and produces a fall of blood pressure. Locally it acts like cocaine as an anesthetic but dilates the blood vessels instead of contracting them. It does not dilate the pupil. It is more irritating to the mucous membrane than cocaine or than beta-eucaine. It has a moderate bactericidal action. It is used as a substitute for cocaine in general and minor surgery but beta-eucaine is preferred for applications to the eye, Dosage.—2 to 5 or even 9 per cent. solutions. Not more than 2 Cc. (30 minims) of a 4 per cent. solution should be used at one time. Manufactured by Chemische Fabrik auf Actien. vorm. E. Schering, Berlin (Schering & Glatz, New York).

ALPHOZONE.

Alphozone. $(COOH.CH_2CH_2CO)_2O_2$—$C_8H_{10}O_8$, an organic peroxide resulting from the action of hydrogen dioxide on succinic anhydride.

Actions and Uses.—Alphozone belongs to the class of organic peroxides, and by its powerful oxidizing power becomes a germicide and antiseptic. Dosage.—Alphozone is also marketed in the form of tablets containing each 0.065 Gm. (1 gr) of alphozone, which are used for making solutions, one tablet to 60 Cc. (2 fluid ounces) of water giving a solution (1 to 1000) suitable for general external use;but, as a nasal douche,one tablet in 180 Cc. (6 fluid ounces) of water is often preferred. Manufactured by F. Stearns & Co., Detroit, Mich.

ALUMNOL.

The aluminium salt of B-naphtholdisulphonic acid, $Al_2(C_{10}H_5.OH.(SO_3)_2)$= $Al_2C_{30}H_{18}O_{21}S_6$.

Actions and Uses.—It is an astringent and mild antiseptic It is claimed that it can be used as a mild astringent, an irritant or a caustic, according to the strength of the soluton, and it is asserted that it exerts a peculiarly destructive action on gonococci It has been recommended for a variety of affections in which a caustic, astringent or antiseptic is indicated. It has been particularly recommended for gonorrhea in females, especially when affecting the ndometr um Dosage.—As a surgical antiseptic, in 0.5 to 3 per cent. solution; in gynecology, in 2 to 5 per cent. solutions; in otology and laryngology, either as powder or in ¼ to 1 per cent, solution as douches washes or gargles; as cautery, in 10 to 20 per cent. solution. Manufactured by Farbwerke. vorm. Meister, Lucius & Bruening, Hoechst a. M. (Victor Koechl & Co., New York).

AMINCFORM.

A name applied to Hexamethylenamina, U. S. P., Sold by C. Bischoff & Co., New York.

ANESTHESIN.

Anesthesin. $C_6H_4(NH_2)(COOC_2H_5)$ 1 :4—$C_9H_{11}O_2N$ the ethyl ester of paramidobenzoic acid, obtained by the reduction of paranitrobenzoic acid.

Actions and Uses.—It was introduced as a substitute for cocaine and is a local anesthetic, similar in its action to orthoform and said to be equally effective, but free from irritant action and toxicity. The anesthetic action, like that of the related compound orthoform, resembles that of cocaine, but is purely local, does not penetrate the mucous membranes and in consequence of its insolubility the co npound can not be used by hypodermic injection In consequence of its insolubility the anesthetic effect is more prolonged than that of cocaine. It is recommended in various forms of gastralgia, in ulcer and cancer of the stomach, for the relief of pain, and is a pplied locally in rhinologic and laryngeal affections, urethritis, etc,; it is also recommended for anesthetizing wounded surfaces, burns, ulcerations and painful affections of the

skin. It is more effective in cases where the skin is broken Dosage.—Internally, 0.3 to 0.5 Gm. (5 to 8 grs.) in pastilles Externally it is applied as a dusting powder, either pure or diluted. It may be applied as an ointment or in the form of suppositories. Manufactured by Farbwerke, vorm. Meister, Lucius & Bruening, Hoechst a. M. (Victor Koechl & Co., New York).

ANTIPYRINE SALICYLATE.

Antipyrine salicylate, $C_{11}H_{12}N_2O.C_6H_4OH.COOH=C_{18}H_{18}N_2O_4$, a weak chemical combination of antipyrine and salicylic acid.

Actions and Uses.—This compound possesses the properties of both antipyrin and salicylic acid and combines the analgesic power of the one with the anti-rheumatic action of the other. It has been used with good results in sciatica, rheumatic fevers, chronic rheumatism, influenza, pleurisy, dysmenorrhea, etc. Dosage.—0.3 to 2.0 Gm. (5 to 30 grains) in cachets or capsules.

ANTITHERMOLINE.

A name applied to a preparation said to be made according to the following formula: Each pound contains 4000 grains of imported washed kaolin, washed and purified, 14 grains boric acid, 14 grains oil of eucalyptus, menthol and thymol combined, and 4.9 fluid ounces of glycerin. It closely resembles the Cataplasma Kaolini, U. S. P. Prepared by G. W. Carnrick Co., New York.

ANTITHYROID PREPARATIONS.

Preparations obtained from the blood or milk of animals, after the removal of the thyroid glands. The use of these preparations is based on the theory that the thyroid gland secretes products which are toxic, but which neutralize, and are neutralized by other toxic substances produced elsewhere in the body. Removal of the thyroid glands, therefore, leads to the accumulation of these second toxic substances as evidenced by the phenomena of cachexia strumipriva and myxedema. On the other hand, the blood or milk of such animals is capable of preventing the effects of a hypersecretion of thyroid substance, such as is supposed to occur in Basedow's disease (exophthalmic goiter). These views are still largely hypothetical; but the majority of clinical observers report markedly beneficial results in the milder forms of the disease and in obscure nervous disorders which are supposedly connected with thyroid hypersecretion. The effects are less pronounced in the more severe forms. The action is merely palliative and other measures of treatment should not be neglected. Improvement occurs in two or three weeks and is indicated by an amelioration of the nervous symptoms, tremors, palpitation, insomnia and excitability. The administration must be long continued. Oral and hypodermic administration are equally effective, but the former is usually preferred. These preparations are not toxic, even when very large doses are used.

ANT THYROIDIN MOEBIUS.

The blood serum of sheep from which the thyroid gland has been removed at least six weeks before the blood is drawn, preserved by the addition of 0.5 per cent. of phenol.

Actions and Uses.—For actions and uses see Antithyroid Preparations. Dosage.—It is administered by the mouth in doses beginning with 0.5 to 1 Cc, (8 to 15 min.) three times a day, gradually increasing the dose as necessary. Manufactured by E. Merck, Darmstadt. (Merck & Co., New York).

ARGENTAMIN.

An aqueous solution of silver nitrate and ethylenediamine, corresponding to 10 per cent of silver nitrate.

Actions and Uses.—It is antiseptic and astringent like other silver salts, with the asserted advantage of being non-irritant and more penetrating than silver nitrate.

It is said to be useful in all cases where the non-caustic action of silver nitrate is indicated. Dosage.—It may be used in the anterior urethra in 0.25 to 1 per cent. solution; in the posterior urethra in from 1 to 4 per ct. solution; in ophthalmology in 5 per cent solution. Manufactured by Chemische Fabrik auf Actien, vorm. E. Schering, Berlin. (Schering & Glatz, New York)

ARGONIN.

A soluble casein compound containing 4.28 per cent. of silver.

Actions and Uses.—Its action and uses are similar to those of silver nitrate, but it is claimed to have greater power of permeating living colloid membranes than other silver albumoses. It is applied as an injection in 0.1 to 0.2 per cent. solution; in ophthalmic practice a 10 to 20 per cent. solution in glycerin may be used. Dosage.—It is generally used in 0.5 per cent. solution, but even 20 per cent. solutions have been ininjected without producing irritant symptoms. Manufactured by Farbewerke vorm. Meister, Lucius & Bruening, Hoechst a. M. (Victor Koechl & Co., New York).

ARGYROL.

A compound of a derived proteid and silver oxide, containing from 20 to 25 per cent. of silver.

Actions and Uses.—Solutions of argyrol (20 to 50 per cent.) are said to be non-irritating to mucous membranes Taken internally it is said to be non-toxic It is claimed to be an antiseptic It is recommended in urethritis and cystitis, in conjunctivitis and in affections of the nose, throat and ear. Dosage.—It is employed in from 10 to 25 per cent. and even stronger solutions. Manufactured by Barnes & Hille, Philadelphia.

NEW AND NON-OFFICIAL REMEDIES.

The following articles have been tentatively approved by the Council on Pharmacy and Chemistry of the American Medical Association. The list will be revised by adding other articles as accepted and by omitting any which on further investigation may be found to conflict with the rules of the Council.

Following the name of each article is the name of the manufacturer, or, in case of foreign products, of the American agent; where no name is given the article is believed to be neither protected by patent nor trademark. The date following the article prefers to the preliminary publication in The Journal A. M. A. When no date is given, the description has not yet been published.

Acetozone (P. D. & Co.), Sept. 15, 1906.

Acetozone Inhalant(P.D. & Co.),Sept. 15, 1906.

Acet-theocinsodium (Cont. Color and Chem. Co.), Sept. 15, 1906.

Adnephrin Emollient (Stearns & Co.), Sept. 15, 1906.

Adnephrin Oil Spray (Stearns & Co.), Sept. 15, 1906.

Adnephrin Solution (Stearns & Co.), Sept. 15, 1906.

Adnephrin Suppositories (Stearns & Co.).

Adrenalin (P. D. & Co.), Sept. 15, 1906.

Adrenalin Chloride Solution (P. D. & Co.), Sept. 15, 1906.

Adrenalin Suppositories (P. D. & Co.), Sept. 15, 1906.

Agurin (Cont. Color & Chem. Co.), Sept. 15, 1906.

Airol (Hoffman-La Roche Chem. Works), Sept. 15, 1906.

Albargin (Koechl & Co.).

Alpha-Eucaine Hydrochloride (Schering & G.), Sept. 15. 1906.
Alphozone (Stearns & Co.), Sept. 15, 1906.
Alphozone Tablets (Stearns & Co.), Sept. 15, 1906.
Alumnol (Koechl & Co.), Sept. 15, 1906.
Alypin (Cont. Color & Chem. Co.).
Aminoform (Bischoff & Co.), Sept. 15, 1906.
Anesthesin (Koechl & Co.), Sept. 15, 1906.
Anthrasol (Knoll & Co.).
Antipyrine Salicylate, Sept. 15, 1906.
Antithermoline, (G. W. Carnrick Co.), Sept, 15, 1906.
Antithyroidin (Merck & Co.), Sept. 15, 1906.
Antithyroid Preparations, Sept. 15, 1906.
Argentamin, (Schering & G.), Sept. 15, 1906.
Argonin (Koechl & Co.), Sept. 15, 1906.
Argyrol (Barnes & Hille), Sept. 15, 1906.
Aristochin(Cont. Color & Chem. Co.), Sept. 22 1906.
Aristol (Cont. Color & Chem. Co.), Sept. 22, 1906.
Aspirin (Cont. Color & Chem. Co.), Sept. 22, 1906.
Benzosol (Koechl & Co.), Sept. 22, 1906.
Beta-Eucaine Hydrochloride (Schering & G.), Sept. 22, 1906.
Beta-Naphthol Benzoate (Merck & Co.), Sept. 22, 1906
Betol (Heyden Chem. Works), Sept. 22, 1906.
Bismal (Merck & Co.), Sept. 22, 1906.
Borochloretone (P. D. & Co.), Sept. 22, 1906.
Brometone (P. D. & Co.), Sept. 22, 1906,
Bromipin—10 per cent. (Merck & Co.) Sept. 29, 1906.
Bromipin—33 1-3 per cent. (Merck & Co.), Sept. 29, 1906.
Butyl-Chloralhydrate Sept. 29, 1906.
Calcium Ichthyol (Merck & Co.), Sept. 29, 1906.
Calomelol (Heyden Chem. Works), Sept. 29, 1906.
Calomelol Ointment (Heyden Chem. Works), Sept. 29, 1906.
Cascara Evacuant (P. D. & Co.), Sept. 29, 1906.
Cascara Tonic Laxative Globules (P. D. & Co.), Sept. 29, 1906.
Chinaphenin (Cont. Color & Chem. Co.), Sept. 29, 1906.
Chloralamid (Schering & G.).
Chlorbutanol, Sept. 29, 1906.
Chloretone (P. D. & Co.), Sept. 29, 1906.
Chloretone Inhalant (P. D. & Co.), Sept. 29, 1906.
Citarin (Cont. Color & Chem. Co.), Sept. 29, 1906.
Collargol (Schering & G.).
Collargol Ointment (Schering & G.).
Cresotal (Cont. Color & Chem. Co.), Oct. 6, 1906.
Cresylone, (P. D. & Co.).
Cupro-Hemol (Merck & Co.).
Dentalone (P. D. & Co.). Oct. 6, 1906.
Dermatol (Koechl & Co.), Oct. 6. 1906.
Diabetin (Schering & Co.), Oct. 6, 1906.
Dionin (Merck & Co,), Oct. 6, 1906.
Diuretin (Merck & Co.), Oct. 6, 1906.
Duotal (Cont. Color & Chem. Co.), Oct. 6, 1906.
Duotonal (Schering & G.), Oct. 6, 1906.
Elixir Eupnein (Schieffelin & Co.), Oct. 6, 1906.
Elixir Saw Palmetto (P. D. & Co.), Oct. 6, 1906.
Empyroform (Schering & G.), Oct. 6, 1906
Epicarin (Cont. Color & Chem. Co.), Oct. 6, 1906.
Erythrol Tetranitrate (Merck & Co.), Oct. 6, 1906.
Ethylenediamine (Schering & G.), Oct. 6. 1906.
Eucaine, Oct. 6, 1906.
Eucaloids (Edward G. Binz), Oct. 6, 1906.
Eucamul (Edward G. Binz), Oct. 13, 1906.
Euformol (P. D. & Co.)
Eugallol (Knoll & Co.), Oct. 13, 1906.
Eumydrin (Cont. Color & Chem. Co.), Oct. 13, 1906.
Euphorin (Fbrk. v. Heyden), Oct. 13, 1906.
Euphthalmin (Schering & G.), Oct. 13, 1906.
Euquinine (Merck & Co.), Oct. 13, 1906.
Euresol (Knoll & Co.), Oct 13, 1906.
Euresol Soap (Knoll & Co.), Oct. 13, 1906.
Europhen (Cont. Color & Chem. Co.), Oct. 13, 1906.

Exodin (Schering & G.).
Ferrichthyol (Merck & Co.),Oct. 13, 1906.
Ferripyrine (Koechl & Co.), Oct. 13, 1906.
Ferropyrine (Knoll & Co.), Oct. 13, 1906.
Formalin (Schering & G.), Oct. 13, 1906.
Formin (Merck & Co.), Oct. 13, 1906.
Gallogen (Bischoff & Co.), Oct. 13, 1906.
Germicidal Soap (P. D. & Co.), Oct. 13, 1906.
Glutol-Schleich (Schering & G.), Oct. 13, 1906.
Glycerin Emollient (P. D. & Co.),Oct. 13, 1906.
Glycerophosphates, Oct. 13, 1906.
Guaiacol-Salol (Merck & Co.), Oct. 13, 1906.
Guaiamar (Mallinckrodt Chem. Works), Oct. 20, 1906.
Guajasanol (Koechl & Co.), Oct. 20, 1906.
Haemoferrum (Stearns & Co.)
Hedonal (Cont. Color & Chem Co.), Oct. 20, 1906.
Helmitol (Cont. Color & Chem Co.), Oct. 20, 1906.
Hemicranin (Cont. Color & Chem. Co.), Oct. 20. 1906.
Hemogallol (Merck & Co.), Oct. 20, 1906.
Hemol (Merck & Co.).
Hemoquinine (Schieffelin & Co.), Oct. 20, 1906.
Heroin (Cont. Color & Chem. Co.), Oct. 20, 1906.
Heroin Hydrochloride (Cont. Color & Che Chem. Co.), Oct. 20, 1906.
Heromal (Schieffelin & Co.), Oct. 20, 1906.
Heroterpine (Schieffelin & Co.), Oct. 20, 1906.
Hetol (Merck & Co.), Oct. 20, 1906.
Hexamethylenamine Methylencitrate, Oct 27, 1906.
Holocaine Hydrochloride (Koechl & Co.), Oct. 27, 1906.
Hypnal (Koechl & Co.), Oct. 27, 1706.
Ichthalbin (Knoll & Co.), Oct. 27, 1906, Nov. 10, 1905.
Ichthammon (F. Reichelt), Oct. 27, 1906.
Ichthargan (Ichthyol Co.), Oct. 27, 1906.
Ichthermol (Merck & Co.), Oct. 27, 1906.
Ichthoform (Merck & Co.), Oct 27, 1906.
Ichthyol (Merck & Co.), Oct. 27, 1906.
Ichthyolum Austriacum (G. Heil & Co.), Oct. 27, 1906.
Iodipin—10 per cent. (Merck & Co.), Oct. 27, 1906.
Iodipin—25 per cent. (Merck & Co.), Nov. 3, 1906.
Iodoformogen (Knoll & Co.), Nov. 3, 1906.
Iodothyrine (Cont. Color & Chem. Co.), Nov. 3, 1906.
Iothion (Cont. Color & Chem. Co.), Nov. 3, 1906.
Isoform Powder (Koechl & Co.), Nov. 3, 1906.
Isopral (Cont. Color & Chem. Co.), Nov. 3 1906.
Kasagra (Stearns & Co), Nov. 3, 1906.
Kola, Stearns, (Stearns & Co.), Nov. 3, 1906.
Kresamine (Schering & G.), Nov. 3, 1906.
Lac Bismo (E. J. Hart & Co.),Nov. 3, 1906.
Lactophenin (Chem. Fbrk. vrm., Goldenberg, Geromont & Co.), Nov. 3, 1906.
Laminoids Ferruginous (Nascent) (Schieffelin & Co.), Nov. 3, 1906.
Lennigallol (Knoll & Co.), Nov. 3, 1906.
Liquor Tritici (P. D. & Co.), Nov. 3, 1906.
Lithium Ichthyol (Merck & Co.), Nov. 3, 1906.
Lycetol (Cont. Color & Chem. Co.),Nov. 3, 1906.
Lysidin (Koechl & Co.), Nov. 3, 1906.
Mercurol (P. D. & Co.), Nov. 3, 1906.
Mesotan (Cont. Color & Chem. Co.), Nov. 3, 1906.
Methaform (Stearns & Co.), Nov. 3, 1906.
Migrainin (Koechl & Co.), Nov. 3, 1906.
Neurocaine (Schieffelin & Co.), Nov. 3, 1906.
Neuronidia (Schieffelin & Co.), Nov. 3, 1906.
Novargan (Heyden Chem. Works).
Novocaine (Koechl & Co.), Nov. 10, 1906.
Nutrose (Koechl & Co.), Nov. 3. 1906.
Oil of Eucalyptus, globules (E. G. Binz).
Organic Iron Preparations.
Orthoform-New (Koechl & Co.), Nov. 10, 1906.
Orthoform-New Hydrochloride (Koechl & Co.), Nov. 10, 1906

Ovoferrin (Barnes & Hille) Nov. 10, 1906.
Oxaphor (Koechl & Co.), Nov. 10, 1906.
Pegnin (Koechl & Co.), Nov. 17, 1906.
Phenacetin (Cont. Color & Chem. Co.), Nov. 10, 1906.
Phenocoll Hydrochloride (Schering & G.), Nov. 10, 1906.
Phenocoll Salicylate, Nov. 10, 1906.
Piperazine (Cont. Color & Chem. Co., Schering & G.), Nov. 17, 1906.
Pollantin (Fritzsche Bros.), Nov. 17, 1906.
Pollantin Powder (Fritzsche Bros.), Nov. 17, 1906.
Protargol (Cont. Color & Chem. Co.),
Purgatin (Knoll & Co.), Nov. 17, 1906.
Pyramidon (Koechl & Co.), Nov. 17, 1906.
Pyramidon Neutral Camphorate (Koechl & Co.), Nov. 17, 1906.
Pyramidon Acid Camphorate (Koechl & Co.), Nov. 17, 1906.
Pyramidon Salicylate (Koechl & Co.), Nov. 17, 1906.
Quartonal (Schering & G.,), Nov. 24, 1906.
Red Bone Marrow (Armour & Co.).
Sajodin (Cont. Color & Chem. Co.).
Sal Ethyl (P. D. & Co.), Nov. 24, 1906.
Saliformin (Merck & Co.), Nov. 24, 1906.
Salit (Heyden Chem. Works), Nov. 24, 1906.
Salophen (Cont. Color & Chem. Co.), Nov. 24, 1906.
Saloquinine (Merck & Co.), Nov. 24, 1906.
Saloquinine Salicylate (Merck & Co.), Nov. 24, 1906.
Santyl (Knoll & Co.).
Sextonol (Schering & Co.), Nov. 24, 1906.
Sidonal (Koechl & Co.), Nov. 24, 1906.
Sodium Cacodylate, Nov. 24, 1906.
Sodium Cinnamate, Nov. 24, 1906.
Sodium Ichthyol (Merck & Co.), Dec. 1, 1906.
Stovaine (Walter F. Sykes), Dec. 1, 1906.
Stypticin (Merck & Co.), Dec. 1, 1906.
Styptol (Knoll & Co.), Dec. 1, 1906.
Styracol (Knoll & Co.), Dec. 1, 1906.
Sublamine (Schering & G.), Dec. 8, 1906.
Sulphonal (Cont. Color & Chem. Co.), Dec. 8, 1906.
Suprarenal Alkaloid, Dec. 8, 1906.
Suprarenal Liquid (P. D. & Co.).
Suprenalin (Armour & Co.).
Suprarenalin Ointment (Armour & Co.).
Suprarenalin Solution (Armour & Co.).
Suprarenalin Triturates (Armour & Co.).
Tannalbin (Knoll & Co.), Dec. 15, 1906.
Tannigen (Cont. Color & Chem. Co.), Dec. 8, 1906.
Tannoform (Merck & Co.), Dec. 15, 1906.
Tannopin (Cont. Color & Chem. Co.) Dec. 15, 1906.
Theobromine, Dec. 15, 1906.
Theobromine Sodium Salicylate, Dec. 15 1906.
Theocin (Cont. Color & Chem Co.), Dec. 22, 1906.
Theophyllin, Dec. 22, 1906.
Thermodin, (Merck & Co.), Dec. 22, 1906.
Thiocol (Hoffman-LaRoche Chm. Works), Dec. 22, 1906.
Thiosinamine (Schering & Co.).
Thyreoidectin (P. D. & Co.).
Tonic Hypophosphites (Sharp & Dohme).
Tonols (Schering & G.), Dec. 22, 1906.
Triferrin (Knoll & Co.).
Triferrol (Knoll & Co.).
Trikresol (Schering & G.).
Trional (Cont. Color & Chem. Co.).
Trioxymethylene (Merck & Co.).
Triphenin (Merck & Co).
Tritipalm (Stearns & Co.).
Tropococain Hydrochloride (Merck & Co.)
Trypsogen (G. W. Carnrick & Co.).
Tumenol-Ammonium (Koechl & Co.).
Tumenol (Koechl & Co.).
Tumenol Sulphone (Koechl & Co.).
Tumenol Sulphonic Acid (Koechl & Co.).
Tussol (Koechl & Co.).
Urethane (Merck & Co.).
Uriform (Schieffelin & Co.).
Uritone (P. D. & Co.).
Uropherin (Merck & G.).
Urotropine (Schering & Co.).
Urotropine-New (Schering & Co.)
Validol (Bischoff & Co.).
Validol Camphoratum (Bischoff & Co.).
Valyl (Koechl & Co.).

Veronal (Merck & Co).
Vibutero (Stearns & Co.).
Vinum Extracti Morrhuae, Stearns, (Stearns & Co.).
Vioform (Bischoff & Co.).
Vioform Gauze (Bischoff & Co.).
Xeroform (Heyden Chem. Works), Sept. 29, 1906, Oct. 13, 1906.

A POCKET CASE FREE.

Dr. E. R. Mason, of Charlotte, N. C., in an able paper in the JOURNAL of the South Carolina Medical Association, entitled "A Plea for a Simpler Materia Medica and More Rational Medication," makes the following strong, clear statement:

"I believe that the use of the active principles is one of the greatest advances in medicine in recent years because it is teaching men to think of the physiological action of drugs, to study the condition of the patient, and apply the drug that is indicated in doses sufficient to produce the desired effect, instead of using complex prescriptions whose physiological action they can only guess."

Doctor, if you want to know more about the advantages of the active principles send your name and address with ten cents, (to cover the cost of mailing), to the Abbott Alkaloidal company, Chicago, and they will send you free this six-vial pocket case filled with representative single active-principles along with other samples and their complete price list.

Make it twenty cents in stamps, and they will include a copy of Dr. Abbott's Alkaloidal Digest, a 300 page crystallization of the essentials of active-principle therapy with clinical applications. This is indeed a very generous offer. It is made to be accepted once only, to every physician who will mention this JOURNAL. We suggest that you write at once. Adv.

Pneumonia—On January 11, 1905, Mr. C——, aged 20, was stabbed in the back below the scapula, and when I saw him twenty minutes after the affray, he was suffering from profound shock. I carried out the usual operative proceedures, and the patient rallied, doing well until the night of the eighth day, when he had a severe chill,presaging pneumonia.

I feared a fatal result, as the left pleural cavity contained considerable bloody serum, and immediately applied a thick dressing of **Antiphlogistine** ten inches wide, from the spinal column to the median line, in the front, and kept up this treatment for three weeks, changing the dressing every morning. By this time the lung was perfectly clear, and there was no further use for the external application.

The **Antiphlogistine** was covered by a cotton jacket and held in place with a cloth bandage. The pain was relieved by hypodermics of mor-

phine and atropine, and the heart was sustained by strychnine. Outside of a little calomel and some laxatives, there was no other treatment. I aspirated the pleural cavity and drew off the serum. In view of the complications in this case, I consider it rather remarkable that the patient made so excellent a recovery. It only confirms my own high opinion of the remedial value of **Antiphlogistine**.—J. A. DAVIS, Norman, Ok. Adv.

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